



NY State of Health
Comments on HHS Notice of Benefit and Payment Parameters for 2020

NY State of Health, the State's Official Health Plan Marketplace submits the following comments on the proposed regulations for 45 CFR Parts 146, 147, 148, 153, 155, and 156; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020 [CMS-9926-P].

NY State of Health notes that the delayed release of the Payment Notice for the 2020 coverage year for comment in January 2019 limits the time that plan issuers have to develop products for plan year 2020 and reduces the period of time that states have to review and approve plan materials prior to certification.

The United States Department of Health and Human Services (HHS) seeks comments on a number of areas of the proposed rule. NY State of Health's comments are set forth below.

I. Executive Summary

- Proposed Rule

HHS expresses concern that the practice of automatic re-enrollment could potentially result in eligibility errors, miscalculation of tax credits, unrecoverable federal spending, and consumers less aware of their options. HHS solicits comment on automatic re-enrollment processes and policies intended to reduce eligibility errors and potential government misspending not sooner than plan year 2021.

- NY State of Health Comments

New York opposes policies that would restrict State-based Marketplaces' automatic re-enrollment processes and capabilities. New York has strong processes in place to ensure the accuracy and integrity of the eligibility determinations. Restrictions on auto-reenrollment would only serve to make it harder for consumers to retain their coverage and thus result in lower enrollment levels, while significantly increasing state IT system and customer service costs.

Under NY State of Health's approved application process, consumers must actively affirm whether they will permit the Marketplace to use federal and state data sources to renew their eligibility. When asked, the overwhelming majority of QHP enrollees eligible for APTC (87 percent) affirmed that the Marketplace could use data sources to re-determine their eligibility for coverage. This allows New York to automate the first of two parts of the renewal process.

Auto-renewal is a two-part process: administrative renewal of eligibility and automatic enrollment into the consumer's same QHP. Consistent with the process in place when a consumer initially enrolls in QHP coverage with financial assistance, at renewal, when data sources for eligibility factors such as income are either not available or do not align with what consumers submit on their application, consumers are required to submit additional

documentation which the Marketplace manually reviews to determine eligibility. Consumers who have been determined to remain QHP eligible can be auto-re-enrolled into their same health plan if it remains available. However, a consumer's coverage is not fully effectuated until they make their first premium payment. Thus, federal tax credits are not issued unless a consumer makes this premium payment to effectuate their coverage.

In New York's experience, automating re-enrollment complements processes that have been put in place to ensure program integrity regarding the disbursement of APTC. Federal and state audits have found that NY State of Health's systems are operating in compliance with federal rules, including income verification to ensure accurate disbursement of APTC.

To undo current automatic re-enrollment processes would require costly IT system changes and increase call volumes to NY State of Health's Customer Service Center, increasing costs further. New York estimates that re-working current automatic re-enrollment processes would cost at least \$7 million. Further, shifting from automatic re-enrollment to manual processes would be more likely to increase rather than decrease eligibility errors, resulting in government misspending.

Elimination of automatic re-enrollment serves no purpose, but makes it more difficult for consumers to stay covered, risking inadvertent gaps in coverage, which raises costs that are borne by consumers.

III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2020

E. Part 155 –Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

2. General Functions of an Exchange
 - a. Consumer Assistance Tools and Programs of an Exchange (§155.205)

- Proposed Rule

The rule proposes to amend 155.205(a) to permit a Small Business Health Options Program (SHOP) operating in the “leaner fashion” to provide a toll-free telephone hotline to answer SHOP-related questions, instead of requiring a toll-free call center. The toll-free telephone hotline will consist of pre-recorded responses to frequently asked questions, information about agents and brokers, and the ability to leave a message if additional information is needed.

- NY State of Health Comments

NY State of Health requests that the transition to a toll-free hotline be optional for states that operate their own SHOP. NY State of Health recognizes the importance of continuing to provide consumers with unbiased information about all plan options and not limiting assistance to pre-recorded messages and agent or broker referrals.

- b. Navigator Program Standards (§155.210)

- Proposed Rule

The proposed rule seeks to amend requirements for navigators in Federally-facilitated Marketplaces by allowing assistance for certain post-enrollment topics to be permissible, instead of required; and to provide additional flexibility regarding training as a result. State-based Marketplaces retain the flexibility to decide whether they will require or authorize Navigators to provide assistance on any or all of the areas described in 155.210(e)(9), which includes post-enrollment assistance. In addition, State-based Marketplaces would have the flexibility to align Navigator training with the type of assistance that is required or authorized.

- NY State of Health Comments

NY State of Health supports the continued flexibility of State-based Marketplaces to determine whether to require Navigators to provide assistance on certain areas described in 155.210(e)(9), including post-enrollment activities, to best address the needs of consumers. NY State of Health also supports the flexibility regarding training, to allow State-based Marketplaces to focus on the training that is appropriate for the type of assistance that is being provided.

- d. Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees enrolling in QHPs (§155.220)

- Proposed Rule

The proposed rule seeks to make significant changes to sections 155.220 and 155.221 to allow states to permit agents, brokers, issuers, and other third parties to assist consumers in enrolling in QHPs. Additionally, the rule seeks to modify prior policy that prohibited Navigators and CACs (“assisters”) from using web-broker websites to assist with QHP selection and enrollment. The proposal would permit, but not require, assisters in FFEs and SBE-FPs, to the extent permitted by state law, to use web-broker websites to assist consumers with QHP selection and enrollment. This proposal is optional for State-based Marketplaces.

- NY State of Health Comments

NY State of Health supports State flexibility for State-based Marketplaces to determine whether to permit agents, brokers, issuers, and third parties to assist consumers in enrolling in QHPs. NY State of Health also supports allowing States and State-based Marketplaces to choose to preserve the prohibition on assisters using web-broker websites.

3. Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

- b. Special Enrollment Periods (§155.420)

- Proposed Rule

The proposed rule amends section 155.420 creating a new special enrollment period (SEP), at the option of the Exchange, for off-Exchange enrollees and their dependents who experience a decrease in household income and are determined newly eligible for APTC. To be eligible for the new SEP, individuals must have been enrolled in minimum essential coverage for at least one of the 60 days preceding the change.

- NY State of Health Comments

NY State of Health strongly supports state flexibility with respect to special enrollment periods.

F. Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

2. Silver Loading

- Proposed Rule

HHS solicits comment on ways in which silver loading may be addressed, in the absence of Congressional action, for future rulemaking not sooner than plan year 2021.

- NY State of Health Comments

New York does not agree that HHS' nonpayment of CSRs is a result of Congress not appropriating funds to pay CSRs, but the result of HHS' unjustified refusal to reimburse insurers for these costs. Nonpayment of CSRs has directly resulted in higher silver plan premiums. Until HHS reverses its decision to stop reimbursing insurers for these costs, states should be permitted to approve silver plan premium rates that take CSR losses into account.

3. Essential Health Benefits Package

- a. State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2020 (§156.111)

- Proposed Rule

HHS sets the deadline for states to submit EHB-benchmark plan selections for the 2021 plan year by May 6, 2019, and May 8, 2020 for the 2022 plan year, two months earlier than the prior year. HHS requests comment on the proposed submission deadlines.

- NY State of Health Comments

NY State of Health requests that the July submission deadline used for the 2020 plan year be maintained for the 2021 plan year to provide sufficient time to consider alternatives and make an appropriate selection.

- e. Premium Adjustment Percentage (§156.130)

- Proposed Rule

HHS proposes to change the methodology to calculate the premium adjustment percentage.

- NY State of Health Comments

New York opposes the revised approach to calculating the premium adjustment percentage because it will increase consumer premium costs and lower QHP enrollment.

CMS' proposed premium adjustment percentage will increase consumers' "applicable percentage" used to determine Premium Tax Credit (PTC) amounts, which will result in higher post-tax credit premiums for consumers. The result of this proposed policy change would be higher consumer premium contributions and lower federal tax credits. We estimate that New

Yorkers would receive nearly *\$40 million less* in federal tax credits in 2020 as a result of this change.

This proposal would result in higher consumer costs and reduced enrollment levels among younger, healthier enrollees, and represents yet another federal proposal that would weaken the stability of the individual market. Numerous federal policy changes, including to risk adjustment, elimination of the individual mandate penalty, nonpayment of cost-sharing reductions, have challenged states' ability to hold premium growth rates consistent with CPI and health care cost trends.

g. Application to Cost-Sharing Requirements and Annual and Lifetime Dollar Limitations (§156.130)

i. Cost-Sharing Requirements for Generic Drugs

- Proposed Rule

HHS proposes several policy changes to cost-sharing requirements, including allowing a plan to exclude a brand name prescription drug from EHB if a generic equivalent is available and medically appropriate. HHS also considers two proposals regarding annual and lifetime cost-sharing limits. Under the first proposal, issuers would be required to attribute the cost sharing of the generic equivalent toward the annual cost-sharing limit. Under the alternative proposal, no amount would be attributed toward the annual limit.

HHS solicits comments on whether the proposed policy should be subject to or preempt state law with respect to cost-sharing between generic and brand name drugs. HHS further solicits comments on whether it should be required, instead of permissible, for issuers to exclude a brand name drug from EHB if a generic equivalent is available and medically appropriate, and to exclude the cost sharing from counting toward the annual limitation on cost sharing based on one of the proposals.

- NY State of Health Comments

NY State of Health supports efforts to encourage generic substitution when medically appropriate, but does not support the proposal to allow health plan issuers to exclude a brand name prescription drug from EHB if a generic drug is available and medically appropriate and thus exclude the cost sharing from counting toward the annual limitation on cost sharing.

Current State law regulates formularies and cost-sharing, and provides standards for prior authorization requests, for purposes of utilization review (UR) determinations for the coverage of prescription drug benefits. The exclusion of brand name drugs from EHB, and the creation of a separate exception or UR process does not align with existing requirements under State law. We support State flexibility with respect to access to prescription drugs that are medically appropriate and controlling costs.

ii. Cost-Sharing Requirements and Drug Manufacturers' Coupons

- Proposed Rule

HHS proposes, beginning with plan year 2020, that amounts paid toward cost sharing using coupons from drug manufacturers to reduce or eliminate out-of-pocket costs for brand name drugs that have generic equivalents, are not required to count toward the annual limitation on cost sharing.

- NY State of Health Comments

NY State of Health supports allowing States to decide how coupons are treated.

4. Segregation of Funds for Abortion Services (§156.280)

- Proposed Rule

HHS proposes, beginning with plan year 2020, to require a QHP issuer that provides coverage of non-Hyde abortion services to also offer at least one “mirror QHP” that omits coverage of non-Hyde abortion services throughout each service area in which it offers QHP coverage through the Exchange, to the extent permissible under state law.

- NY State of Health Comments

The HHS proposal with respect to mirror coverage that omits abortion services is not permissible under New York law, which provides that no policy delivered or issued for delivery in the state that provides hospital, surgical, or medical expense coverage shall limit or exclude coverage for medically necessary abortion, subject to limited exception. 11 NYCRR 52.16(o), 11 NYCRR 52.1(p)(1).

NY State of Health appreciates HHS’ consideration of these comments and looks forward to continuing to work with our federal partners to refine the proposed regulations.