December 30, 2020

The Honorable Seema Verma
Administrator, Centers for Medicare and Medicaid Services
200 Independence Ave, SW
Washington, DC 20201

RE: 2022 Notice of Benefits and Payment Parameters for and Pharmacy Benefit Manager Standards—CMS-9914-P

Submitted Electronically via www.regulations.gov

Dear Ms. Verma:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. We are pleased to have the opportunity to provide comments in response to the proposed rule titled "Patient Protection and Affordable Care Act: 2022 Notice of Benefits and Payment Parameters for and Pharmacy Benefit Manager Standards," referenced as CMS-9914-P.

The members of NAHU work daily to help millions of individuals and employers purchase, administer, and utilize health insurance coverage. Since the Patient Protection and Affordable Care Act (ACA) passed, our members have worked directly and tirelessly with millions of individuals and employers of all sizes to help them obtain new coverage and comply with new requirements. Their work includes placing coverage through both the individual and Small Business Health Options Program (SHOP) marketplaces. Ensuring market stability and competition and improving health coverage affordability are among our association's top goals. Our comments are organized by section, and they reflect the views of experts who fully understand the needs and interests of today's individual and group health insurance consumers.

EXCHANGE DIRECT ENROLLMENT OPTIONS (§ 155)

The proposed rule would allow each state to forgo the traditional exchange options of utilizing, either fully or partially, the services of the federal exchange marketplace and Healthcare.Gov or operating a traditional state-based exchange. Instead, the rule would allow them to opt for an exchange based on direct enrollment. This option would be accessible to states that operate their own exchanges and those that rely on the federally facilitated marketplace in all ranges of capacity. If a state elected this option, it would need to maintain a centralized website with basic statutory-required information.

However, with the direct enrollment (Exchange DE) alternative, all consumers would connect with and enroll in marketplace-based qualified health plans (QHPs) and related premium tax credits via private-sector entities. The proposed rule anticipates that both issuers and entities that HHS classifies as web-brokers will conduct the direct enrollment activities, as they do in a more limited capacity currently. The rule also allows for the participation of traditional independent agents and brokers and exchange-based navigators and assisters. The rule includes a wide range of safeguards and verification and readiness standards for states and entities that elect to participate in the Exchange DE option.

NAHU members appreciate the Trump Administration's intent with this proposal and HHS's faith in private-market enrollment channels. However, based on direct-enrollment experience to date, in many cases, this option detracts from the consumer's ability to seek the expert advice of state-licensed health insurance producers and other forms of direct consumer assistance. Web-brokers often provide a very different enrollment experience than an independent agent who works with enrollees personally. Professional advice and the year-round service that comes with utilizing an independent agent are often not readily available or accessible in the current iteration of direct enrollment in the marketplace. The State of Georgia recently obtained a Section 1332 ACA waiver to create an individual marketplace based on private enrollment channels, but that marketplace is not up and running yet. In its development, the state had to make modifications to allow true independent agent participation, and that process is still ongoing.

Our members are not sure that the Exchange DE model proposed will genuinely result in meaningful participation for independent agents and other forms of direct customer assistance. NAHU members also are concerned that lower-income individuals and families will miss opportunities to access Medicaid and the Children's Health Insurance Program if one or more family members qualify since the Exchange DE model will not support these programs. Due to inconsistent qualifying income levels by age and family status for these programs in many states, different family members are often eligible for various coverage options—some public and some private. While qualified individuals may still access Medicaid and CHIP through other channels in an Exchange DE state, that option seems to eliminate the "no wrong door" enrollment element that is a vital part of any traditional exchange marketplace.

Currently, if any state would like to create an enrollment option like the Exchange DE model, it would need to go through the Section 1332 waiver process. This process requires public and stakeholder input and contains policy and financial guardrails. NAHU members believe that the current approach is sufficient to meet state-level flexibility needs in this area. We recommend that the Section 1332 waiver remain the only way a state can opt to develop an exchange alternative for its residents.

VERIFICATION PROCESS RELATED TO ELIGIBILITY FOR INSURANCE AFFORDABILITY PROGRAMS (§ 155.320)

The ACA established that people who have enrolled in any employer-sponsored health coverage or are eligible for group coverage that meets federal affordability and minimum value standards are ineligible to receive federal tax subsidies offered through the health insurance exchanges. HHS originally planned to take an active role in verifying employer-coverage offers and enrollment as part of the subsidy-eligibility process. However, since 2014, HHS has been using a limited verification process, relying on the subsidy applicant's information, electronic verification data, and information from a random sampling of employers. In the proposed rule, CMS indicates that it is considering eliminating the random employer sampling process, as it yields low participation and usable data from employers. Further, CMS proposes to take no enforcement action against exchanges that fail to perform random sampling through 2022.

As we have commented many times previously, NAHU remains very concerned about the workability and effectiveness of the employer coverage verification, notice, and appeals processes as they currently stand with health insurance exchanges. NAHU believes that adequate exchange-based verification of qualified offers of employer-sponsored coverage would prevent many individuals from receiving subsidies inappropriately. It would also reduce the IRC §4980H employer shared responsibility penalty enforcement burden for both the IRS and employers nationally.

Given that HHS and the IRS have consistently elected not to coordinate on eligibility verification, NAHU requests that both entities contemplate a simple process for employers to help with this process. Employers that comply should be held harmless for any employees who obtain subsidized exchange-based coverage inappropriately. HHS could do this very effectively by:

- Establishing a simple web-based platform or landing page for an employer to enter necessary contact information (business address, email, phone number, contact name). The federally facilitated and state-based exchanges could use this data to verify an individual's exchange coverage application.
- Providing employers with a second, voluntary option to prospectively report information with the IRS before annual open enrollment. The federally facilitated and state-based exchanges could use this information to verify coverage offers that meet the employer shared responsibility (4890H) affordability and minimum-value tests.

Our membership works directly with both employers that offer people qualified affordable and minimum-value coverage and individual exchange consumers. So, NAHU members have a great deal of insight into why employees with a qualified offer of employer-sponsored coverage might decline such coverage in favor of exchange-based offerings. We would be happy to provide information, and we encourage you to contact us for this purpose.

SPECIAL ENROLLMENT PERIODS (§ 155.420)

The proposed rule would allow people access to special enrollment periods (SEPs) for three new coverage situations. The first would be to give special SEP eligibility to individuals already enrolled in exchange-based coverage but who lose their eligibility for an advanced premium tax credit mid-plan-year due to increased family income. This special eligibility would be limited in purpose to allow affected enrollees and their dependents to enroll in a new QHP of a lower metal level. Another proposed SEP eligibility change would apply to all SEP-eligible individuals who did not take advantage of their election period because they did not receive timely notice of their triggering event. The proposed rule would allow these people to select a new plan within 60 days of the date that they knew, or reasonably should have known, about their SEP rights. People eligible for this type of SEP could choose an effective date based on their original triggering event, allowing for potential retroactive eligibility. SEP rights would exist for both exchange-based and off-exchange private individual coverage. Finally, the proposed rule would allow people whose employer completely ceases to subsidize their COBRA premiums with access to a new SEP. The SEP-triggering event would be the last day of the period for which COBRA continuation coverage was paid for by the employer in whole or in part.

Beyond the three new SEPs proposed, the rule contemplates whether it would help to allow SEP eligibility if an employer reduces, but does not entirely cease, its contributions to COBRA continuation coverage. In addition, the preamble to the rule asks if HHS should adopt a threshold for the level of reduction of employer contributions for COBRA-continuation coverage that should trigger a special enrollment period.

Concerning the three proposed changes, health insurance agents and brokers often encounter people who would be positively affected by each of these concepts. We appreciate how your agency is being responsive to real-life SEP needs. However, we also feel it is important to point out that adverse selection in the individual market is a real concern, particularly with COBRA beneficiaries. The result of increased individual-market claims experience is, in the end, higher premium costs, which affects everyone -- including the federal government in the form of higher subsidy costs.

NAHU members also want to ensure that HHS understands the employer-facing effect of the current proposal to create a SEP for people who completely lose prior employer-sponsored subsidization of the COBRA continuation coverage premiums. These effects would also apply if HHS finalized the possibility contemplated in the proposed rule of a new SEP for people who face a reduction in COBRA subsidies provided by their employer. While employees in this situation certainly experience an economic impact that could cause them to drop COBRA coverage and go bare without access to a new SEP, there is also the employer's side to consider.

From a benefit-administration perspective, this SEP would be complicated for employers. Employer documentation will be necessary to verify SEP eligibility, and current employer COBRA administration would need significant modification to provide it. Also, a change of this kind could significantly impact employer-provided severance packages in the future. NAHU members believe that a SEP-qualification standard based on the loss or reduction of employer-provided COBRA subsidies and the resulting employer-based administrative complications could substantially reduce the number of employers willing to subsidize coverage for any length of time moving forward.

PUBLICATION OF THE PREMIUM-ADJUSTMENT PERCENTAGE, MAXIMUM ANNUAL LIMITATION ON COST SHARING, REDUCED MAXIMUM ANNUAL LIMITATION ON COST SHARING, AND REQUIRED CONTRIBUTION PERCENTAGE (§ 156.130)

NAHU members support the proposal that beginning with the 2023 benefit year, HHS would publish the premium-adjustment percentage, along with the maximum annual limitation on cost-sharing, the reduced maximum annual limit on cost-sharing, and the required contribution percentage. Publication would be in guidance by January of the year preceding the applicable benefit year unless HHS is amending the methodology to calculate these parameters. This information affects both individual and employer-based coverage of all types. Having access to it earlier and by a consistent date will help health plan administration and service for virtually all privately insured Americans.

NETWORK ADEQUACY STANDARDS (§ 156.230)

NAHU members appreciate the clarification in the proposed rule that nothing in the ACA requires a QHP issuer to use a provider network. Accordingly, an issuer may choose to design a QHP that does not use a provider network and to provide equal benefits for covered services without regard to whether the issuer has a network participation agreement with the provider that furnishes the covered services. Therefore, according to HHS, Section 156.230 of the CFR regarding network adequacy standards does not impose any adequacy certification requirement for QHPs that do not use a provider network. To address any ambiguity, the proposed rule would codify that a plan that does not vary benefits based on whether the issuer has a network participation agreement with the provider that furnishes the covered services does not need to comply with the network adequacy standards to be certified as a QHP. Our association believes this clarification is important, particularly as issuers move toward more innovative plan designs that do not utilize traditional provider networks and consumers benefit from plan cost-transparency requirements that could change network structures and provider contracting in the future.

QUALITY RATING SYSTEM (§ 156.1120) AND ENROLLEE SATISFACTION SURVEY (§ 156.1125)

NAHU members support HHS's concept of working to streamline and improve consumer understanding of the information available via Healthcare.Gov's quality rating system. A plan's overall score must be more reflective of clinical quality measures. Our association also agrees with the idea to

make the annual QHP Enrollee Survey results publicly available in a yearly public use file. Transparency in this area should only help to improve enrollee experience and quality of care.

ENROLLMENT PROCESS FOR QUALIFIED INDIVIDUALS (§156.1240)

The regulation clarifies that QHP issuers are required to accept a variety of payment methods so that individuals buying individual coverage have a wide range of options when making monthly premium payments. The proposed rule extends these same payment flexibility requirements to individual-market QHP issuers regarding payments made on behalf of an enrollee from an individual-coverage HRA or QSEHRA. Allowable reimbursement may include employee-initiated payments made through the use of financial instruments, such as pre-paid debit cards, direct payments, individual or aggregate, by the employer, employee organization, or other plan sponsors or the health insurance issuer. According to the new rule, issuers must also accept premiums received directly from an individual-coverage HRA or QSEHRA made on behalf of an enrollee covered by the individual-coverage HRA or QSEHRA. NAHU supports this clarification and changes to the payment requirements.

MEDICAL LOSS RATIO CHANGES (§ 158)

The proposed rule makes a definitional change to describe prescription drug rebates and related manufacturer price concessions for medical loss ratio (MLR) calculation purposes. The new definition includes all direct and indirect remuneration received by an insurer and entities providing PBM services regardless of who gets the payment. The rule also creates a broad standard for what counts as direct and indirect remuneration. It would include discounts, charge-backs or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits offered to some or all purchasers.

According to this measure, the new definitions would affect MLR calculations for the 2022 reporting year. While the preamble to the rule indicates that HHS believes this is sufficient time for PBM contract adjustments, NAHU members want to clarify that the new data that will be needed is not readily available currently. We are not sure that the current timeframe is sufficient and propose a 2023 implementation date instead.

In addition to the new PBM requirements, the proposed rule would alter MLR requirements related to the COVID-19 pandemic, using pandemic-related experience to ease MLR requirements during any future public health emergencies. The proposal would use existing interim MLR data reporting and rebate requirements for the 2021 MLR reporting year and beyond for individual and small-group market insurers that elect to offer temporary premium credits during a declared public health emergency.

The measure also builds on existing coronavirus-related guidance allowing issuers to pre-pay rebates in the form of premium credits this year. HHS wants to allow insurers to pre-pay estimated rebates for any MLR reporting year regardless of the payment format. The rule also would allow this at any time during the year, so long as insurers do so for all eligible enrollees in a given state and market in a nondiscriminatory manner. Based on our experience in the marketplace, NAHU members are not sure that this type of rebate prepayment is necessary. Nor is it always helpful, particularly to group plans. This year, the pre-paid rebates have led to many administrative hassles and questions from group health plan sponsors since many of the pre-paid rebates are in tiny dollar amounts. Accounting for them, and distributing them equitably and in a manner that meets ERISA plan fiduciary standards can be burdensome. Accordingly, our association does not see the need to justify an alteration of existing MLR rebate distribution processes for ERISA group health plans outside of a longstanding public health emergency.

PRESCRIPTION DRUG DISTRIBUTION AND COST REPORTING BY PHARMACY BENEFIT MANAGERS (§§ 184.10 AND 184.50)

The proposed rule would require PBMs that participate in federal health programs such as Medicare Part D and the exchanges to provide certain prescription drug information to the Department of Health and Human Services. PBMs will need to disclose information about:

(1) the volume of prescription drug claims;
(2) how prescriptions are filled based on the type of pharmacy;
(3) detailed data about manufacturer rebates, including where rebate funds go; and
(4) the aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays pharmacies.

The proposal requires PBMs to provide this information. It exempts QHPs that contract with a PBM to administer their drug benefits from needing to disclose the information directly, since the PBM has access to this data. NAHU members support this proposal. It reflects the market reality in terms of the source of the information and it should improve price transparency in the marketplace.

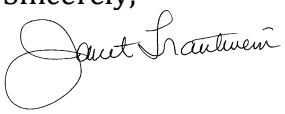
STATE INNOVATION WAIVERS—31 CFR PART 33 AND 45 CFR PART 155

Section 1332 of the ACA allows each state the chance to waive specific requirements in the law and instead craft health-reform solutions that best meet the needs of their residents. States need to meet certain fiscal guardrails and policy parameters to qualify for a Section 1332 waiver, and, ultimately, the federal executive branch has approval authority. The proposed rule would codify existing sub-regulatory guidance, published in 2018, on the Section 1332 process. NAHU members support this proposal since we feel it will provide certainty to states that may be considering applying for a Section 1332 waiver or are developing an application.

We sincerely appreciate the opportunity to voice our viewpoint on the proposed rule. We are also

grateful for your commitment to gathering the views of all stakeholders about these critical topics. If you have any questions about our comments or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,



Janet Stokes Trautwein
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