



**COMMENTS to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, CMS-9926-P**

**RE: CMS Notice of Benefit and Payment Parameters for 2020**

Submitted by Community Catalyst  
February 19, 2019

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) in response to the proposed Notice of Benefit and Payment Parameters for 2020, posted on January 24, 2019.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

We appreciate the opportunity to provide comments. However, we are concerned by the delayed release of this proposed rule and the compression of the public comment period to less than 30 days from the date of publication in the Federal Register. Given the delay, we recognize the importance of finalizing this rule as soon as possible, but reasonable time for consumers, advocates and other stakeholders to meaningfully comment should remain a priority. In future rulemaking, we urge the Departments to adopt a comment period of at least 30 days from rule publication and to fully comply with notice-and-comment requirements under the Administrative Procedure Act.

**Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets**

**§ 147.106(e) – Mid-year prescription drug formulary changes**

We generally support CMS's proposal to allow mid-year formulary changes, as permitted by state law, to allow insurers to update their prescription drug formularies when a generic equivalent becomes available on the market. However, we believe CMS should increase the length of the advance notice requirement to enrollees from 60 days to at least 90 days and include continuity of care provisions for access to brand name drugs where medically necessary.

We appreciate that mid-year formulary changes could result in access to lower cost prescription drugs for enrollees who are able to continue their course of treatment with a generic equivalent. However, for some consumers, the generic equivalent of a brand name drug may not meet their medical needs. Because many enrollees pick their plans based on the prescription drug benefit, we urge CMS to ensure all consumers who may be affected by this change to have access to an exceptions process as required under the EHB regulations at 45 CFR 156.122(c). That process has more consumer protective time frames and requirements than are required under the appeals process outlined in 45 CFR 147.136, including the requirement that any out-of-pocket costs incurred for a non-formulary drug that has been found to be medically necessary must count toward the annual limit on out-of-pocket costs.

With the addition of more time to work with a health care provider to understand how the changes might impact an enrollees' course of treatment, and the addition of a process to allow for continuity of care for enrollees where medically necessary, these mid-year formulary changes can achieve the stated purpose of increasing access to lower-cost drugs while also protection patients who might need access to the name brand version.

### **Part 155 - Exchange Establishment Standards and Other Related Standards under the Affordable Care Act**

#### **§§ 155.210; 155.220; 155.221 and 155.420**

**Navigator Program Standards:** We strongly oppose the proposal to make post-enrollment assistance an optional duty for Navigator programs. Our experience with the enrollment assistance community has taught us that individuals need significant help with post-enrollment activities such as health insurance literacy, applying for appeals and exemptions and understanding the Advanced Premium Tax Credit (APTC) reconciliation process. According to the proposed rule, CMS proposes this change to reduce “regulatory burden” on assisters and to “better meet consumers’ needs.” However, **we firmly believe that if CMS wants to meet consumers’ needs, then the best way to achieve this goal is to reinvest full funding to the Navigator program.**

Robust and comprehensive enrollment assistance does not stop at enrollment. Helping consumers gain and maintain effective health coverage requires assisting with post-enrollment needs in addition to the application and plan selection process. Assisters are uniquely positioned to provide post-enrollment assistance because they are often the first point of contact for consumers who have post-enrollment questions, such as how to access care, find a provider or file an appeal. Additionally, once the open enrollment period has ended, assister organizations have significantly more time to dedicate to providing post-enrollment assistance. Therefore, there is no need to remove this requirement so that Navigators can better “prioritize work according to consumer demand, community need and organizational resources.” **We urge CMS to keep the current requirement in place, to continue training navigators in post-enrollment activities and to refocus navigator reform efforts on properly funding the program.**

**Direct Enrollment:** Although we appreciate the modest enhancements to oversight authority and display requirement restrictions, we reiterate our position that web-broker websites are not an adequate substitute for HealthCare.gov. Web-broker websites do not contain important HealthCare.gov features such as the functionality to create an account through which they can update their application information and allow for an application to be sent to the relevant state Medicaid agency for an eligibility determination if an individual or family is potentially eligible for Medicaid.

Not only do web-broker websites fall short of providing individuals with the complete suite of features and services that HealthCare.gov provides, they also contain features that put individuals at risk of enrolling in a plan that does not meet their needs. For example, although CMS proposes restrictions around incentive-based recommendations, this offers limited protection because direct enrollment sites are only required to provide hyperlinks to marketplace plans they don't sell, rather than full plan information that would allow consumers to see and compare all marketplace plans available to them.

If CMS finalizes the change as proposed, however, **we urge the agency to prohibit web-broker sites from reflecting a preference for certain plans, require them to display all marketplace plan information in an impartial manner so that the displays exactly replicate those found on HealthCare.gov, and restore funding to the navigator program to ensure consumers continue to have access to impartial enrollment assistance.**

**Special Enrollment Periods:** We applaud CMS for the proposed changes to extend a special enrollment period (SEP) to off-marketplace enrollees enrolled in ACA coverage who experience a mid-year change in income that makes the individual newly eligible for APTCs. This not only aligns SEP opportunities on and off the marketplace, but also with employer coverage where there is an SEP available for those who become newly eligible for APTCs because of a change in the minimum value or affordability of their plan. Allowing individuals outside of the marketplace to access subsidies if their income drops mid-year is an important consumer protection and we urge CMS to finalize this change as proposed.

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

#### **§§ 156.111; 156.125; 156.130 and 156.280**

**Silver Loading:** We appreciate that CMS seeks comment on the practice of silver loading before making any permanent changes. We believe there is a clear legal obligation of insurers to provide plans with cost-sharing reductions (CSRs) to consumers who qualify, and in the absence of a Congressional appropriation, the practice of silver loading is a rational way to fulfill this obligation. We also believe that consumers enrolling in QHPs, including those who have benefited from lower-cost plans as the result of silver loading, should be held harmless in any future administrative or legislative change to the practice of silver loading or the appropriation of funds for CSR payments. Until the time that CMS or Congress finds a solution that will not raise premiums for consumers and lower the buying power of the APTC, **we urge CMS to continue to allow states, acting in their role as the primary regulators of health insurance, to allow**

**or require marketplace insurers to recover the cost of CSR payments through the practice of silver loading.**

**State Selection of EHB-Benchmark Plans:** We have no objections related to the proposed timeline for states to select an EHB-benchmark plan, according to the flexibility finalized in last year's rule changes, but **we urge CMS to strictly enforce the required public notice and comment requirements and consider expanding this process to include states intending to allow substitution across benefit categories.**

CMS currently requires a state to provide "reasonable public notice and an opportunity for public comment on the State's selection of an EHB-benchmark plan that includes posting a notice on its opportunity for public comment with associated information on a relevant state website." Even so, CMS did not strictly enforce this requirement last year as one state sought to make benchmark changes having released no information to the public about the proposed changes to allow for reasonable notice and comment period. Moving forward, CMS should only approve requested changes from states that comply with this requirement and, in particular, make public detailed information about the proposed changes along with the actuarial report the state intends to submit to CMS during the state comment period.

We also urge CMS to require this same public notice and opportunity for public comment when a state intends to allow substitution across benefit categories. If a state chooses to allow this flexibility, it will make it harder for consumers to compare plans with certainty that covered benefits are comparable. Moreover, insurers could use this substitution leeway to avoid enrolling patients with preexisting conditions. Therefore, it's critical for CMS to require the same level of notice and comment as afforded to other changes in the provision of EHB.

In addition to transparency at the state level, CMS should also provide an opportunity to comment on these proposals at the federal level. In 2015, the last time states had the opportunity to change their EHB benchmark plan selection, CCIIO provided a federal comment period and posted plan documents for review. This process did not take place in 2018, and we urge CMS to reinstate a federal comment process moving forward.

**Medication-Assisted Treatment for Opioid Use Disorders:** We applaud CMS for elevating the importance of medication-assisted treatment (MAT). MAT is an evidence-based strategy that includes medication and psychotherapy or other counseling and is currently the most effective treatment available to treat opioid addiction. There are several drugs approved for use with MAT, including methadone, naltrexone, and buprenorphine. However, current coverage of MAT is limited under many plans. **We support CMS' recommendation that insurers provide comprehensive coverage of MAT, thereby increasing access to MAT and normalizing its use.**

**Premium Adjustment Percentage:** We strongly oppose the proposal to change the premium adjustment percentage formula because it will increase out-of-pocket costs for enrollees and result in individuals losing coverage. According to the estimates in the proposed rule, the changes to the premium adjustment percentage formula will result in a decline of approximately

100,000 marketplace enrollees in 2020, most of whom will go uninsured, as well as premium increases of over \$180 million from 2020-23.

We believe the justification provided for this change is inadequate and contrary to the legislative intent of the financial assistance structure of the ACA.<sup>1</sup> As indicated in the proposed rule, CMS states that the formula changes will “additionally reduce federal premium tax credit expenditures.” The primary purpose of providing Advanced Premium Tax Credits to marketplace enrollees is so that the federal government, rather than low-income individuals and families, bears the burden of any premium increases in the individual market. We strongly believe that access to quality, affordable health coverage cannot be compromised for the purpose of reducing federal spending. Therefore, **we urge CMS not to make this change and instead keep the current premium adjustment percentage formula in place.**

**Segregation of Funds for Abortion Services:** We urge CMS not to finalize the proposed changes that would require those insurers which offer plans that include abortion coverage to also offer a “mirror plan” without abortion coverage, as this provision would be in conflict with Congressional intent and the language of the ACA. Additionally, this requirement will impose additional costs and administrative burdens on insurers, and potentially discourage offering of plans covering abortion.

Under current law, insurers offering plans on the marketplace can elect whether or not to provide abortion as part of a health insurance plan, unless prohibited by state law. CMS states in the proposed rule that current law does not prohibit CMS from requiring issuers to offer “mirror” plans that do not include abortion coverage. However, we believe that if Congress intended to require mirror plans such provision would have been contemplated and included in the law, given the extent to which Congress debated insurance coverage of abortion in the marketplaces before passage of the ACA. In fact, requiring a mirror plan clearly violates current law, which gives plans the option to include or not to include this coverage.

Additionally, by the administration's own admission in the proposed rule, this proposal will pose significant burdens on insurers, as well as states that allow abortion coverage, since state will now be obliged to monitor how insurers are offering these mirror plans. The proposed rule also acknowledges that the increased costs and administrative burdens imposed on issuers could lead them to drop abortion coverage entirely. Coupled with the recent proposed regulations regarding program integrity of the exchanges and separate billing requirements for abortion services, these changes will impose unnecessary costs on insurers and undoubtedly lead to insurers dropping plans that include abortion coverage.

Restrictions to abortion coverage continue to disproportionately impact low and moderate-income individuals and amplify existing health disparities, disproportionately harming people who already face barriers to accessing quality health care, due to their socioeconomic status, gender, gender identity, sexual orientation and/or race. **We strongly oppose the suggested**

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<sup>1</sup> Levitis, J. (2019). *Indexing provision in HHS proposed marketplace regulations is not just bad policy, but could be vulnerable to legal challenge*. USC-Brookings Schaeffer Initiative for Health Policy. Retrieved 19 February 2019, from <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/02/14/indexing-provision-in-hhs-proposed-marketplace-regulations-is-not-just-bad-policy-but-could-be-vulnerable-to-legal-challenge/>

**changes in the proposed rule because restrictions to a full range of pregnancy-related care, including abortion, can mean long-term, devastating effects on individuals and their families' economic future.**

Thank you for this opportunity to comment.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Michael Miller".

Michael Miller  
Director, Strategic Policy  
Community Catalyst