pennsylvania
INSURANCE DEPARTMENT

February 19, 2019

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9926-P
P.O. Box 8016
Baltimore, MD 21244-8016

Via Regulations.gov

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed Notice of Benefit and Payment Parameters for 2020 (Notice), as published in the *Federal Register* on January 24, 2019. As the primary regulator of health insurance in Pennsylvania, the Pennsylvania Insurance Department is working tirelessly to foster an affordable and accessible health insurance market in the Commonwealth.

We believe two key elements to achieving this goal are certainty and preparation. We have concerns that by issuing the Notice for the 2020 plan year so close in time to the filing deadlines, the Centers for Medicare and Medicaid Services (CMS) has compromised valuable time for issuers to prepare their product filings, and has left issuers without certainty regarding the rules that govern the market they are participating in. We respectfully request that in future plan years, the Notice be issued in the fall prior to the filing deadline, similar to previous product filing cycles, to provide issuers with certainty and allow adequate time to prepare product filings.

In addition to the timing of the Notice, we offer the following comments on the substance of the Notice for plan year 2020.

Silver Loading

We appreciate CMS seeking comments on silver loading and therefore allowing us the opportunity to voice our strong support for the continuation of the program into the future, absent Congressional action. When the federal Administration ended the Affordable Care Act's (ACA's) cost-sharing reduction (CSR) payments, which were intended to lower copayments and deductibles for exchange enrollees with annual incomes below 250% of the federal poverty level, the requirement that issuers reduce cost-sharing for lower-income enrollees remained in place. We worked with issuers in the Pennsylvania market to allow for silver loading, enabling issuers to increase premiums on silver-level plans to compensate for the increased actuarial value that the plans provided to enrollees.

Silver loading allowed us to avoid severe market destabilization following the discontinuation of CSR funding. The defunding of CSR threatened increased costs for consumers, which risked significant enrollment drops, while also threatening a loss of coverage options for consumers and non-participation by issuers. Instead, Pennsylvania was able to work toward achieving stability in our market by mitigating the financial consequences of CMS's actions on consumers, while making more options affordable for consumers. Further, we worked with the issuers in the Commonwealth to conduct consumer outreach to those who were not eligible to receive subsidies to ensure they enrolled in a plan that avoided unnecessary financial burdens.

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Silver loading is a necessary practice for market stability and insurer solvency, unless and until Congressional action is taken to resume CSR funding. We request that in the absence of Congressional action, CMS take no action through rulemaking to limit the strategies that states may use to avoid having consumers endure the harmful impact of CSR defunding. We believe that silver loading as a cost-containment and market-stabilization strategy has allowed our market to continue on a path toward stabilization; any curtailing of silver loading risks swift destabilization as the costs borne by consumers would dramatically increase and likely decrease issuer participation in the individual market.

Automatic Re-enrollment

CMS requested comment on automatic re-enrollment, and we appreciate the opportunity to voice our support for the continuation of the practice. Automatic re-enrollment provides an important consumer protection by providing a default circumstance of coverage, rather than lack of coverage, when a consumer does not take action during the open enrollment period. Our Department invests considerable resources to reach out to consumers leading up to and during the open enrollment season to emphasize the importance of shopping for coverage since costs, provider networks and participating issuers may have changed and there may be a better coverage option available. However, we also appreciate that extenuating circumstances may prevent some enrollees from taking action during open enrollment. In these instances, we support the automatic re-enrollment mechanism that assures that the individual will continue to have coverage in the same or most similar plan offered on the exchange.

The population that is assisted by the automatic re-enrollment process is significant. Approximately 1.8 million federally facilitated marketplace enrollees who did not actively dis-enroll or switch plans were automatically renewed into coverage, with premium subsidies if eligible, for the 2019 plan year. If CMS were to discontinue auto re-enrollment, many of these individuals could become uninsured or experience an unexpected gap in coverage.

We are cognizant that the re-enrollment process has its challenges, and we support CMS's suggestion of a discussion of processes or policies to implement that may reduce eligibility errors and continue prudence with regard to responsible government spending. Likewise, we will continue to vigorously highlight the importance of shopping for coverage during open enrollment season to Pennsylvanians. However, while these efforts take place, we fully support the continuation of automatic re-enrollment, as it enables coverage to be the default option rather than non-coverage.

Drug Formulary Changes

We appreciate CMS's proposal to allow issuers to add a generic equivalent of a drug to a formulary in the middle of a plan year, as we are all pursuing ways to make health care more affordable to consumers, and a requisite aspect of this effort is a closer review of pharmaceutical costs. However, we have concerns regarding the details of CMS's proposal to allow mid-year formulary changes, especially with regard to how consumers will be notified of and impacted by such important changes. (At the same time, we appreciate the preamble statement that CMS is not seeking to prevent states from prohibiting or limiting the impact of such changes.)

CMS proposes to allow an issuer to exclude a brand name product from the Essential Health Benefits (EHB) if an issuer covers both a brand name drug and its generic equivalent. If the brand name drug were no longer a required EHB, issuers could then subject such brand name drugs to annual or lifetime dollar limits, and patients' cost-sharing towards these drugs would not count towards their annual cap on out-of-pocket spending. Issuers would still be required to allow patients to seek exceptions only if the brand name product is medically appropriate. Changing a drug's availability and cost-sharing in the middle of a plan year is highly disruptive for individuals that rely on a formulary at the time of purchase to be reflective of the access to drugs throughout the

plan year. In addition to adding comprehensive notice protections for consumers, we encourage CMS to consider the mid-year exclusion of a drug from EHB to be an adverse benefit determination that would trigger an enrollee's right to appeal.

Separately, CMS proposes to allow issuers to disregard the value of drug manufacturers' coupons in an enrollee's out-of-pocket maximum calculation when a generic equivalent is available. Some drug manufacturers provide coupons to patients to help reduce their out-of-pocket costs. By helping ensure that drug cost-sharing is affordable for consumers, especially given the proliferation of high-deductible coverage, copayment support can encourage adherence to medication regimens. Some issuers and pharmacy benefit managers have recently adopted accumulator adjustment programs where they no longer apply a copay or other manufacturer coupon to an enrollee's deductible or out-of-pocket maximum, and CMS proposes to continue this approach. While this policy would put downward pressure on manufacturers' prices for some prescription drugs, and thus on premiums, they risk doing so at the expense of enrollees. If finalized, we urge CMS consider clarifying that this proposal would not prevent a state from prohibiting or limiting how issuers accumulate cost sharing; state regulators are best positioned to decide whether these particular tools for reducing prescription drug costs are appropriate for their states.

Premium Adjustment Percentage

The Notice proposes to update the methodology for calculating the premium adjustment percentage, which is the factor used to determine the annual adjustment in the amount subsidized marketplace enrollees contribute to plan premiums, the cap on annual out-of-pocket spending, the amount issuers pay via the health insurance tax, and the fine for employers who fail to offer affordable coverage to their employees. The update to the methodology would change the measure of premium growth from only employer plans to the premium growth across all private plans. The measure was limited previously because of the volatility of the premiums in the individual market skewing the integrity of the measure. We have concerns that previous volatility issues remain with the updated approach, the abrupt transition from measuring only employer plans' growth to measuring all private plans will have harmful consequences that may be avoided by gradually transitioning to the broader measure over several years, and that the proposed change in approach could face legal challenges.

The consequences of flipping this switch in one year would be severe: the proposed change in formula will result in net premium increases of over $180 million per year and a decline of approximately 100,000 marketplace enrollees in 2020. Those with high cost health conditions or injuries could face an additional $400 in out-of-pocket spending next year. The premium increases will greatly impact subsidized enrollees, while the increase in annual out-of-pocket spending will extend the negative and abrupt consequences to employer-based coverage as well. Reduced federal support and fewer enrollees would not be helpful for our market as we continue to work toward stability.

We urge CMS to reconsider whether a change to the premium adjustment percentage is necessary and prudent. If CMS determines a change is warranted, we suggest CMS identify an approach that alleviates the skewing of data attributable to the volatility in the individual market. Further, we suggest CMS employ a more gradual transition to using individual market premiums in the formula for the premium adjustment percentage. CMS could employ a transitional approach – blending the existing formula, using employer-sponsored insurance premiums, with the proposed formula, using the broader measure of premiums for private health insurance – gradually tapering the weight applied to employer-sponsored premiums. This approach would help avoid a reduction in premium tax credits so large in any one year that it causes a significant number of people to become uninsured, regressing on the coverage gains that we have worked so hard to achieve. Finally, we suggest CMS pursue any change through a legally sound path and resolve the legal deficiencies of the current approach.

Prohibition on Discrimination

We commend CMS's continued encouragement of coverage for Medication Assisted Treatment (MAT) for purposes of treating opioid use disorder, and appreciate the concerns raised about parity vis-à-vis the coverage of MAT. CMS notes that it is aware that some issuers are excluding the coverage of MAT when used for opioid treatment but covering the same MAT drugs for other medically necessary purposes. Given this, CMS reminds issuers of EHB nondiscrimination requirements, which prohibit discrimination in benefit design or the implementation of benefit design based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Specifically, a reduction in the generosity of a benefit for subsets of individuals that is not grounded in evidence-based reasonable medical management practices is potentially discriminatory. Thus, if a plan excludes certain treatment for opioid use disorder but covers the same treatment for other medically necessary purposes, the issuer must be able to justify its exclusion and show that its benefit design is not discriminatory.

The Wolf Administration is working extensively to encourage access to MAT, and to ensure that, when used for treating opioid use disorder, it is offered on par with other conditions. We successfully worked with the major commercial issuers in the Commonwealth to remove prior authorizations for MAT and require access to MAT on the lowest cost formulary tier for patients. In addition, prior authorization requirements for MAT were removed in the Pennsylvania Medicaid program, in both the managed care and fee-for-service delivery systems. We are likewise cognizant of potential violations of mental health parity laws as we conduct market conduct examinations across the major health issuers in the Commonwealth. We commend the position that CMS has taken with regard to MAT; it dovetails with our multi-faceted approach to encouraging access to MAT and addressing the opioid crisis in this country.

Navigator Funding

Finally, we support allowing Navigators to focus their efforts on their local needs, tailoring their work to the nuanced aspects of the community they serve. However, we remain concerned about reduced funding for both Navigators and for general outreach regarding marketplace coverage. Marketing, outreach and Navigator funding are some of the core functions of operating the federally facilitated marketplace (FFM), and the federal government is falling short of meeting those expectations. In Pennsylvania, we have stepped in where the federal government is failing; for the 2019 open enrollment period, we funded and operationalized our own outreach campaign to make sure accurate information reached consumers, but not every FFM state has the ability to do this and our state resources are more limited than the federal government's. We urge CMS to review their current funding for these programs and provide sufficient resources in future years.

Thank you for the opportunity to comment. We remain open to engaging with CMS to offer our perspective as state regulators, and we are available to discuss the issues we have highlighted in this response or other topics covered by the Notice while it is being finalized.

Sincerely,

Jessica K. Altman
Commissioner