January 27, 2022

*Submitted electronically*

Centers for Medicare & Medicaid Services, Department of Health and Human Services,
Attention: CMS-9911-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: 2023 Notice of Benefit and Payment Parameters (NBPP)

Thank you for the opportunity to provide comments on the proposed Notice of Benefit and Payment Parameters for 2023 Proposed Rule (NBPP). The Council for Affordable Health Coverage (CAHC) and the Health Benefits Institute (HBI) have long supported increasing access to affordable health coverage, and welcome the chance to provide actionable feedback to CMS as it considers modifications to the exchanges and requirements for insurers.

CAHC (www.cahc.net) is a broad-based alliance with a primary focus: bringing down the cost of health care for all Americans. Our members include employers, medical providers, patient groups, insurers, agents and brokers, technology companies, pharmaceutical manufacturers, and pharmacy benefit managers who collectively cover millions of lives in the private market.

The Health Benefits Institute is a policy organization supported by agents, brokers, insurers, employers, benefit platforms and others seeking to protect the ability of consumers to make their own health care financing choices. We support policies that expand consumer choice and control, promote industry standards, educate consumers on their options and foster high quality health outcomes through transparency in health care prices, quality, and the financing mechanisms used to pay for care.

Taken as a whole, we are concerned that the direction of the NBPP would lead to many more restrictions on plan offerings and could result in the types of ACA markets consumers experienced between 2015-2017. These markets were characterized by few plan offerings and increasing premiums and out-of-pocket costs that made coverage unattractive for many. We urge you to adopt policies that promote flexibility and innovation in benefit design so that competition brings costs down while expanding choice. Our detailed comments to that end are outlined below.

**GUARANTEED AVAILABILITY OF COVERAGE (§ 147.104)**
**PAST-DUE PREMIUMS**
The proposed rule would not allow insurers to collect past-due premiums from consumers:

> We propose to re-interpret the guaranteed availability requirement at section 2702 of the PHS Act and its implementing regulation at § 147.104 to require issuers to accept individuals and employers who apply for coverage, even where the individual or

> employer owes past-due premiums for coverage from the same issuer or another issuer in the same controlled group.

Unfortunately, we believe the long-term impact of this proposal will result in low-income consumers being harmed through fewer plan choices, and higher costs. The proposal incentivizes consumers to avoid paying owed premiums for the last three months of the year, and leaves insurers without a way to respond. The net result will be some consumers gaming the system leading to higher premiums, higher federal deficits, and less availability of coverage. It could lead to insurers avoiding areas where consumers actively engage in this practice, potentially culminating in regions with fewer plan choices.

**RISK ADJUSTMENT ISSUER DATA REQUIREMENTS (§§ 153.610, 153.700, AND 153.710) PROPOSAL TO EXPAND PERMISSIBLE USES OF EDGE DATA**

The proposed rule expands the use of EDGE Data beyond the current uses. EDGE server data is created for one primary purpose, and we believe the use of this data beyond the current scope is unwise. First, EDGE server data has significant limitations, and an expansion of both the number of data elements and the use of those elements creates reliability issues. Indeed, relying on the data provided has considerable limits even at present, especially because the data is self-reported. We believe that EDGE data should continue to be used in its current limited capacity.

Specifically, we have concerns regarding the following:

> In this section, we propose that issuers collect and make available for HHS' extraction from issuers' EDGE servers five new data elements—ZIP code, race, ethnicity, an ICHRA indicator, and a subsidy indicator (APTC indicator at the policy-level)—as part of the required risk adjustment data that issuers must make accessible to HHS in states where HHS operates the risk adjustment program…

We do not believe all this data will be available to insurers – indeed many state laws bar the collection of race and ethnicity in insurance data. In other cases, insurers may not differentiate between ICHRA and non-ICHRA consumers, making the data invalid. These new data elements are also outside of the existing data points collected by EDGE servers and will require significant IT costs to implement with data that is available.

**ABILITY OF STATES TO PERMIT AGENTS AND BROKERS AND WEB-BROKERS TO ASSIST QUALIFIED INDIVIDUALS, QUALIFIED EMPLOYERS, OR QUALIFIED EMPLOYEES ENROLLING IN QHPS (§ 155.220)**

This section includes a number of new requirements and limits for agents, brokers, and web brokers in assisting consumers:

> We propose to amend § 155.220(c)(3)(i)(A) to include at proposed new §§ 155.220(c)(3)(i)(A)(1) through (c)(3)(i)(A)(5) a list of the QHP comparative information web-broker non-Exchange websites are required to display consistent with § 155.205(b)(1). We also propose to revise the disclaimer requirement in

> § 155.220(c)(3)(i)(A) so that web-broker non-Exchange websites would be required to prominently display a standardized disclaimer provided by HHS stating that enrollment support is available on the Exchange website and provide a web link to the Exchange website where enrollment support for a QHP is not available using the web-broker's non-Exchange website.

We remain concerned that the main goal of all of these changes is to make it more difficult for innovative web brokers to serve their customers. Indeed, the sum of the proposals appear to be an attempt to ensure that consumers only shop on the federal exchange website. In short, we believe some of these changes will harm the consumer experience and add little value to consumers.

Specifically, all web brokers provide consumers with the ability to customize their shopping experience. This is what differentiates these services from the federal exchange website and from each other. Overlaying new federal requirements merely complicates the process for all parties and ensures the consumer experience will be forced to reflect federal preferences rather than providing a tailored consumer experience.

Even more problematic is the requirement that web brokers provide a description of their proprietary methodology for helping consumers pick plans. It will be virtually impossible to write a description that concisely explains the complicated algorithms to a consumer. In short, it is information that will either not be useful to a consumer or too long and complicated to be read and understood by the layperson.

**FFE USER FEE RATES FOR THE 2023 BENEFIT YEAR**

The NBPP maintains the proposed 2.75% user fee. This high fee made sense at that the start of the ACA and the high costs associated with an exchange at that time. However, technology costs have dropped considerably over time, and the proposed user fee is out of step with the costs of running the exchange. These fees are largely paid by consumers in the form of higher premiums, and contribute to higher overall health insurance premiums, ultimately leading to a deterioration of the risk pool especially for unsubsidized consumers. We urge you to consider lowering the user fee.

**LEVELS OF COVERAGE (ACTUARIAL VALUE) (§§ 156.140, 156.200, 156.400)**

The proposed changes in the actuarial value will drive up premiums, increase medical costs, reduce consumer choice, and lead to higher federal expenditure. The proposal states the following:

> HHS proposes to change the de minimis ranges at § 156.140(c) beginning in PY 2023 to +2/−2 percentage points for all individual and small group market plans subject to the AV requirements under the EHB package, other than for expanded bronze plans, for which HHS proposes a de minimis range of +5/−2. Under § 156.200, HHS proposes, as a condition of QHP certification, to limit the de minimis range to +2/0 percentage points for individual market silver QHPs; HHS also proposes under § 156.400 to specify a de minimis range of +1/0 percentage points for income-based silver CSR plan variations.

We do not support the reduction in plan design flexibility by again re-defining the de minimis range to +/- 2 %. Many consumers will be shocked at the impact on premiums, and will be forced to change their benefit plans. Further, manipulating the proposed silver plan de minimis to only +2% will drive up premium costs, and artificially drive up subsidies. These proposed changes will significantly destabilize the insurance market.

**FFE NETWORK ADEQUACY STANDARDS BEGINNING WITH PY 2023 (§ 156.230)**

We do not support the modification of the network adequacy requirements. While we understand CMS' desire to ensure that enrollees have access to providers, the proposed FFE QHP certification standards are not the way to achieve that goal. The proposed certification criteria would merely create additional burden on issuers, while ignoring the reality of the state-to-state and region-to-region variation in provider networks. There has been a long-standing shortage of health care providers, a trend that has only been exacerbated by the pandemic. Clinicians have stopped practicing for a myriad of reasons, and day-to-day staff shortages due to COVID infection are commonplace. The provider shortage is felt acutely in rural areas, where it is often difficult to see any provider close by, especially specialists.

In light of this, it is doubtful that additional burdensome standards at the federal level would achieve CMS' stated goals without dramatically increasing costs. We firmly support the goal of enhancing consumer access to quality providers, and doing so in an equitable way. However, due to the complexity of the provider situation state-to-state, any network adequacy changes ought to be done at the state level. State regulators understand best the unique needs of the consumers in their states and are much better situated to implement the appropriate policies to achieve better access to care for their constituents. We urge CMS to retain the current network adequacy requirements.

**ESSENTIAL COMMUNITY PROVIDERS (§ 156.235)**

HHS has proposed two specific changes. The first would require all QHP's to enroll 35% of Essential Community Providers (ECP) in their network. In order to meet the standard, the ECP's must be in the lowest cost tier.

While we understand the interest in this issue, we believe the proposed 35% standard in the least cost tier will be too onerous for insurers to meet. It is important to remember that as little as five years ago the ACA market was failing, indeed over half the counties had only one health insurer offering coverage in the ACA market. Onerous and potentially costly requirements like this one will bring about the return of failing ACA markets, ultimately hurting consumers the most.

**STANDARDS FOR DOWNSTREAM AND DELEGATED ENTITIES (§ 156.340)**

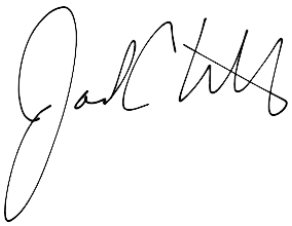
The proposed language in the rule is overly broad, and may have a chilling impact on the market. Specifically, it states:

> We propose to amend and add language to § 156.340 to extend the existing downstream and delegated standards to QHP issuers on all Exchange models, including State Exchanges and State Exchange SHOPs, and Exchange models that use the Federal platform, including, FFEs, SBE-FPs, FF-SHOPs; and HHS also proposes to add a requirement that all agreements between QHP issuers and their downstream and delegated entities include language stating that the relevant Exchange authority, including State Exchanges, may demand and receive the downstream or delegated entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with Federal standards under paragraph (a) of this section until 10 years from the final date of the agreement period.

The proposal opens up access to numerous private consumer and business records housed in entities not regulated by insurance departments, exchanges, or HHS. It includes no limits in the ability to access the data. The greatly expanded access to private data is worrisome on its own, but the proposal as written does not provide for even basic oversight. This proposal is unwise, and we cannot support it.

Thank you again for providing an opportunity to comment on NBPP. Please do not hesitate to reach out if you have further questions at joel.white@cahc.net or jpwieske@thehealthbenefitsinstitute.org.

Sincerely,



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