February 28, 2020

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attn: CMS-9916-P

P.O. 8016

Baltimore, MD 21244-8016

**Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020 - CMS–9926–P**

To Whom It May Concern:

The Silver State Health Insurance Exchange (hereinafter, the Exchange), the state agency tasked by statute with oversight and operation of Nevada’s public health insurance marketplace, appreciates your consideration of the following comments related to the Notice of Benefit and Payment Parameters for 2021 (CMS-9916-P) proposed rule.

The Exchange thanks the Administration for the continued commitment to preserving States’ autonomy as it relates to the management of their health insurance markets and to protect the authority exercised by State-based Exchanges (SBEs) to control implementation of policy, operations, and technical improvements to their marketplaces. The Exchange is concerned, however, that some of the policies proposed or raised for comment in the Payment Notice would likely undermine the stability and viability of the Exchanges and the individual market as a whole by making coverage more costly for consumers or creating additional barriers to health care access. We respectfully offer the following comments and recommendations addressing specific provisions of the proposed rule.

*Automatic re-enrollment*

The proposed rule solicits comment on the prohibition of automatic re-enrollment or the reduction of advance premium tax credits (APTC) for certain enrollees elected to automatically renew on an annual basis. Such a change would usurp the States’ autonomy and authority while also imposing unnecessary operational burdens. If promulgated as written the change would require the Exchange to make technological code and rule changes while also absorbing a heavy administrative load - both of which create fiscal burdens with an unknown cost for the agency. Consumers would be impacted negatively in Nevada and at a nationwide level, as the prohibition would specifically target those consumers who receive enough APTC to cover their entire monthly premium. These consumers are often in the lowest qualifying income brackets and thus, most in need of assistance to maintain reliable and consistent health insurance coverage with appropriate subsidies. These consumers rely on auto-renewal without the need to take action and have provided explicit consent for auto-renewal as they recognize it is in their best interest. Such a change is unnecessary, highly confusing, disruptive to all exchange markets, and creates an undeniable barrier to access for those most in need.

In general the Exchange agrees that enrollees are well-served by visiting the marketplace during the annual open enrollment period to ensure household and income information is up-to-date and evaluate plan options. The Exchange markets to all consumers including those who are elected to auto-renew, and encourage them to shop for coverage. We believe that adequately funded marketing and outreach can inform enrollees of the value of returning to the Exchange each year, while strongly-supported consumer assistance can facilitate coverage shopping and active re-enrollment. Furthermore, CMS has provided no evidence that auto-reenrollment for this particular group of marketplace consumers creates increased risk of errors. This particular proposed change may be attempting to engineer a solution without evidence of a problem, while ignoring negative effects.We do not support eliminating the automatic re-enrollment process for individuals who are enrolled in $0 plans due to their amount of APTC, nor do we support the reduction of a consumer’s APTC during automatic re-enrollment if they are enrolled in a $0 plan and believe that granting less APTC than a consumer is eligible for unilaterally, is counter to the best interest of the consumer.

Automatic re-enrollment reduces burdens on both consumers and issuers. Without it, enrollment through the Exchanges would certainly be reduced. Moreover, because those who are currently healthy and use less care are likely to avail themselves of automatic re-enrollment at higher rates than those who anticipate using medical services, it is probable that limiting this option would cause the individual market risk pools to shrink and become more predominantly unhealthy. This in turn would likely lead to higher premiums and potentially reduced issuer participation; two issues that are particularly concerning in Nevada. Congress made clear, both when it passed the Affordable Care Act (ACA) and recently with the passage of an amendment to section 1311(c) of the ACA, that consumers are to receive prompt and continuous eligibility and enrollment. The proposed approach put forward by the Administration is contrary to law. We strongly urge the Administration to maintain the automatic re-enrollment process as is. We also strongly encourage the Administration to allow for states to have autonomy in decision-making related to auto-renewals, since marketplace problems and solutions will be diverse.

*Special enrollment periods (§155.420)*

The proposed rule highlights changes to Special Enrollment Periods (SEPs) related to consumers who become newly ineligible for cost sharing reductions (CSRs) to allow enrollment into a metal level higher or lower. The Exchange understands the importance of affordability for consumers who may be losing their CSRs and agrees with the Administration’s decision to allow states the autonomy in choosing whether to implement this change. The rule also proposes other changes, such as the time between a consumer enrollment in a plan and the effective date of coverage, as well as changes to the retroactive effective dates and prospective coverage related the binder payment rules. We understand this is a benefit to consumers and the Exchange recommends allowing states to have autonomy in implementing such changes. Such changes would require complex technological rule and coding modifications that may come with an unknown and unplanned fiscal burden.

*Maximum Out Of Pocket (MOOP) limits*

The Exchange recognizes and understands there will be an average of 4.9% increase in a consumer’s MOOP costs from plan year 2020 to plan year 2021. This increase will impact every individual market consumer in all exchanges across the nation. In Nevada it is currently estimated that [NUMBER] people are covered with the 2020 MOOP on their enrollment. For 2021 adding the 4.9% increase this is a total of $400 annually for an average of $33 monthly. This change would have an exponentially more detrimental effect on families. Nevada’s population of consumers enrolled in family plans is estimated at [PERCENTAGE HIGHER THAN INDIVIDUAL PLANS]. This increase would impose an estimated annual cost of an additional $800 and monthly estimated cost of $66. We strongly encourage the administration to implement stabilizing measures to reduce and or mitigate negative financial impacts on consumers.

*FFE and SBE-FP User Fee Rates for the 2020 Benefit Year (§155.50)*

Nevada has transitioned from the federal platform to a State-Based Exchange in part to remove the budgetary uncertainty that results from the administration’s annual fluctuating user fee. Operating as a State-Based Exchange not only allows for cost savings and transparency, it also provides increased budget and operational stability. While we recognize that the Payment Notice identifies the general factors that determine the proposed FFE and SBE-FP user fee rates for the 2021 benefit year, we respectfully urge the administration to adopt a more predictable and transparent approach to the calculation of the user fee rates, by providing greater detail about the share of costs associated with each of the functions performed by the federal platform.

*Eligibility Pending Appeals (§155.525)*

The Payment Notice solicits comments related to clarification for eligibility rules during an appeal and the possibility of allowing consumers to select another plan and/or switch insurers. Such rules would require substantial technological rule and code changes that would likely come with a significant financial burden. In addition, such a change would be extremely confusing for consumers who would likely struggle to understand the potential impacts of changing a plan during a pending appeal. We encourage CMS to allow states their autonomy in decision-making related to the potential proposal of this rule in future years in order to best serve their unique populations.

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We look forward to working with the Department on these proposals and in our ongoing efforts to improve access to affordable Exchange coverage.

Thank you for your time and attention. Please feel free to contact me should you have any questions or require any additional information.

Respectfully,



Heather Korbulic

Executive Director

Silver State Health Insurance Exchange