March 2, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-9916-P

Dear Administrator Verma:

The Healthcare Leadership Council (HLC) thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to submit comments in response to the notice of proposed rulemaking entitled, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans."

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

HLC appreciates CMS's efforts to minimize the number of significant regulatory changes to provide states and issuers with a more stable and predictable regulatory framework that facilitates a more efficient and competitive market. We have reviewed the proposed HHS Notice of Benefit and Payment Parameters for 2021 and offer comments on the following provisions:

Silver Loading

We were pleased to see CMS not propose any changes to "silver loading," specifically limiting states' ability to increase the cost of the premiums on the silver tier plans for which a cost sharing reduction is offered.

Risk Adjustment Data Validation (RADV)

HLC supports CMS's proposal to allow the 2019 benefit year of RADV serve as a second pilot year for the purposes of prescription drug data validation, in addition to the 2018 benefit year RADV pilot for prescription drugs. Allowing 2019 to be another pilot year will provide more time and experience before prescription drug data validation results would be used to adjust risk scores.

Value-Based Insurance Design (VBID)

HLC is highly supportive of the concept behind VBID. However, we are unsure if having a designation for a VBID plan on the exchange makes sense at this time. Consumers are not familiar with the term "value-based insurance design," as it is used mostly by the health insurance industry and academia.

Medical Loss Ratio (MLR)

HHS proposes to amend a provision requiring issuers to deduct from incurred claims (and report as non-claims costs) prescription drug rebates and other "price concessions" not only when received and retained by the issuer, but also when received and retained by an entity providing pharmacy benefit managers (PBM) services to the issuer. We believe in order to provide issuers with regulatory certainty, HHS should consider conducting additional rulemaking on the definition of "price concession" in the actual MLR regulatory text. The definition should be defined and transparent so its purpose is clear to all parties. HHS should align the MLR definition with the elements of "price concession" proposed in the Paperwork Reduction Act notice on PBM transparency in coverage reporting by qualified health plan issuers. Additionally, HHS should ensure that any definition of "price concession" is narrowed to not include compensation that issuers pay to PBMs, such as administrative fees.

Auto Re-enrollment

HHS proposes to modify the automatic reenrollment process for enrollees who have $0 premium responsibility after the Advance Premium Tax Credit (APTC) is applied by automatically reenrolling these individuals but without applying APTC, or by reducing APTC for this population to a level that would result in an enrollee premium that is greater than zero dollars. HLC opposes this proposal to automatically reenroll fully subsidized individuals without APTC, or with a reduced APTC. We strongly urge HHS to continue the current auto re-enrollment process for the 2021 plan year and beyond. We also recommend that HHS and Department of Treasury work together to better define and report on the problem. For example, of the 270,000 people HHS said were automatically re-enrolled into fully-subsidized coverage in 2019, it would be helpful to understand how many received too much APTC and how many of those were not required to repay due to repayment caps.

Auto re-enrollment is a core exchange process that consumers, issuers, and exchanges have come to rely on since it was implemented for the 2015 plan year. Most individuals who receive $0 APTC have incomes between 100 percent and 130 percent of the Federal Poverty Level and are among the most vulnerable enrollees. We are concerned that CMS communications may not reach these enrollees or may be confusing resulting in loss of coverage for many. While these individuals would continue to be re-enrolled in coverage, without subsidies, or with reduced subsidies,

many would be unable to afford their monthly premiums. These individuals would lose their coverage and be forced to wait until the next open enrollment period to enroll in coverage unless they experience a qualifying event. This could be particularly devastating for a consumer who has experienced a major health event and is in the middle of a course of treatment, for example.

Thank you for the opportunity to provide comments on this proposed rule. HLC looks forward to continuing to engage with the administration as the regulatory process proceeds. If you have any questions or need additional information, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org

Sincerely,

Mary R. Grealy
President