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December 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 2022 - CMS–9914–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 2022 (CMS-9914-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 protecting 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.

Enhanced Direct Enrollment (EDE)/Direct Enrollment (DE) (§155.221)

The Exchange is opposed to the proposed rule change to add 45 CFR § 155.221(j) to allow a new Direct Enrollment option beginning in PY 2022, for several reasons, including consumer confusion, increased potential for fraud, and the lack of knowledge or data regarding potentially negative downstream effects of the outlined model.

SBEs rely on consumer messages that point consumers to shop for coverage from a trusted source such as the Exchange. The single entity model offers a consistent means of ensuring that consumers can easily find accurate and official information while being able to trust a clear and authoritative source of that information. The messaging that can come from an EDE/DE source

can contain confusing information including to but not limited to: the offering of plans that are not compliant with the Affordable Care Act (ACA); where to shop for plans; eligibility for Medicaid, CHIP, or other public coverage programs, as well as the availability and use of advanced premium tax credits (APTC). Historical experience has shown that providing consistent and comprehensive messaging in a longstanding relationship with consumers lessens confusion, and avoids forcing consumers to shop on multiple sites or attain unreasonable levels of consumer expertise for something that should always be about easing consumer experience. We believe this is consistently evidenced by the lack of engagement from SBEs in the DE process to date.

Additionally, we oppose this option because of the greatly increased potential for fraud. While many private sector participants would work diligently to reduce the confusion consumers could face from a decentralized model, there are operatives who would see it as an opportunity to mislead unknowing consumers in order to gain commissions, enroll consumers in plans not well suited to their needs, or sell different products entirely while being able to advertise themselves as "official" QHP enrollment entities.

At this point no evidence has been put forward that the proposed changes would benefit consumers in securing coverage. Based on the lack of SBE participation with DE engagement, the proposed rule would expand the presence of DE, despite lack of interest or data to warrant that expansion.

Special enrollment periods (§155.420)

Special Enrollment Period Verification Standards -

While the Exchange already has special enrollment period validation practices in place, we encourage CMS to continue to give states the flexibility to set verification standards and monitor those set standards.

The proposed rule does not cite any evidence that there is a current, significant, or ongoing problem due to current Exchange practices regarding SEP verification. At the very least, implementing a new requirement for a matter that has not been shown to be an issue to date is unnecessary, but more concerning is that seeking mandated solutions where there is no evidence of a problem may very well create unnecessary administrative burdens for SBEs and SBE-FPs.

Such changes for states to meet this proposed requirement would come with changes to technology platforms, changes in existing staff duties, requirement to add new positions, or some combination thereof. Those changes, even if only to address reporting, will further burden Exchange operations and take away from focus on putting consumers' needs first. This is further complicated by the fact that the proposed change, while acknowledging different approaches to verification could be approved, provides no examples of what "verification" is acceptable, meaning that states cannot currently plan for or even understand what, if anything, they would be required to alter operationally, nor the full cost of said changes.

Untimely Notice of Triggering Events -

The Silver State Health Insurance Exchange applauds the decision to adjust the SEP timeframe based on untimely notices of triggering events. As we have seen during this pandemic there are many reasons why a consumer may not be made aware of a triggering event until late in the 60-day window, or even after it has passed.

We also support the proposed rules change to allow consumers to select the earliest effective date for coverage that would have been available if he or she had received timely notice of the triggering event. In addition to the change in timeline due to the timely notice proposal, this will help ensure that consumers stand a better chance of minimizing, or avoiding altogether, a gap in coverage, particularly in difficult circumstances or uncertainty.

Exchange Enrollees Newly Ineligible for APTC

The Exchange supports the proposal to allow enrollees newly ineligible for APTC to switch to a lower metal level plan. However, we encourage you to allow states flexibility to not limit the changing of plans to a certain metal level.

The changes in the proposed rule would require substantial technology changes to limit one's shopping availability. This would require an unknown financial expense to the Exchange as well as direct consumer impact and messaging.

Rebating Premium if the Applicable Medical Loss Radio Standard is Not Met (§158.240)

The Exchange was required to implement significant changes to our exisiting technology to align with the guidance published August 4, 2020 regarding Temoprary Policy on 2020 Premium Credits Associated with the COVID-19 Public Health Emergency. The changes required an enormous lift of administrative hours on both the Exchange staff, vendor staff, as well as a substantial fiscal burden the Exchange was not expecting nor prepared for. The rule is proposing to finalize this temporary policy and allow issuer to continue to allow premium credits.

Although the premium credits are beneficial for consumers, the impact to a State-Based Exchange (SBE) creates operational risks as well as negative finaicial strain. The Exchange supports the temporary policy which details the issuer must receive permission from any applicable Exchange through which they offer qualified health plan (QHP) coverage. The Exchange understands the need for the rule, however requests HHS to provide more clarification on the criteria for the temporary guidance while maintaining the issuer receive the required approval from the Exchange prior to issuing a premium credit.

Employer-Sponsored Coverage Verification (§155.320)

The Exchange understands the need to ensure that only those Nevada consumers eligible for APTCs and CSRs are receiving them. The proposed rule indicates there is still ongoing analysis

being completed by the Department of Health and Human Services (HHS) to find the most effective way of conducting verification of employer-sponsored coverage for consumers indicating they have unaffordable employer-sponsored coverage. The Exchange encourages HHS and CMS the provide each state the flexibility to conduct their own verification to standards that best represent each state's population of consumers.

Without more detailed information pertaining to the verification measures or threshold requirement while preparing for the 2022 plan year as proposed, states are left with less flexibility to make these changes as needed. Until there is sufficient analysis completed by HHS we propose to allow states to select their verification method and set a threshold that doesn't impose a higher level of administrative burden on States conducting the random sample of verifications.

Maximum Out Of Pocket (MOOP) limits

The Exchange recognizes there is a proposed average 6.1% increase in consumers' MOOP costs from plan year 2021 to plan year 2022. This increase comes from the increase of 6.4% to the applicable percentage. The increase to the MOOP limits will impact every individual market consumer in all exchanges across the nation. For 2022, adding the 6.1% increase this is a total of $550 annually for an average of $45 monthly. In addition, this change would have an exponentially more detrimental effect on families. This increase would impose an estimated annual cost of an additional $1,100 and monthly estimated cost of $91. We strongly encourage the administration to implement stabilizing measures to reduce and or mitigate negative financial impacts on consumers specifically to decrease the applicable percentage allowing for more flexibility to lower the MOOP limits

FFE and SBE-FP User Fee Rates for the 2022 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 annually 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 2022 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. Furthermore, we have concerns that the continued lowering of the user fee poses a threat to the reality of costs required to effectively meet the operational requirements set out in the Affordable Care Act.

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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