



December 29, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9914-P
P.O. Box 8016
Baltimore, MD
21244-8016

Submitted electronically via www.regulations.gov

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332) Implementing Regulations—AHIP Comments

Dear Administrator Verma:

On behalf of America's Health Insurance Plans (AHIP), thank you for the opportunity to offer comments in response to the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards ("Payment Notice") and Updates to State Innovation Waiver (Section 1332) Implementing Regulations, published in the *Federal Register* on December 4, 2020 (CMS-9914-P).¹

The COVID-19 pandemic and resulting economic crisis has shown it is more important than ever for consumers to have affordable coverage options to protect their health and financial security. AHIP and its member health insurance providers are committed to offering coverage options in every Exchange and every county to ensure all Americans have coverage and access to vital vaccines, treatments, and other health care to promote wellbeing during this uncertain time.

The Affordable Care Act's (ACA's) health insurance exchanges are functioning better than ever. Preliminary reports for healthcare.gov 2020 open enrollment show 8.2 million enrollments. Adjusted year-over-year trends show enrollment has steadily grown, with a 6.6 percent increase in plan selections from last year.² Qualified health plan (QHP) issuer participation continues to increase, with issuers expanding into new markets resulting in more choices for consumers. Operational processes that support exchange enrollment such as auto reenrollment and enhanced direct enrollment continue to improve. As currently designed, all enrollment options provide reliable, accurate information and a seamless consumer experience.

Moving forward, stability is a key priority for encouraging QHP issuer participation, promoting choice and competition, and encouraging Americans to get and stay covered. We appreciate the Administration's

¹ AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. Americans deserve access to comprehensive, quality, affordable coverage. AHIP is committed to advancing policy solutions in support of this goal.

² CMS Federal Health Insurance Exchange Weekly Enrollment Snapshot: Week Six. December 18, 2020

commitment to regulatory stability, streamlined regulations, and improved exchange operations. This ongoing partnership is critical to ensure affordable coverage options, competition, and programmatic stability.

With these goals in mind, AHIP's recommendations focus on two themes: (1) promoting stability and predictability for plan year 2022 by ensuring critical information is finalized in a timely manner; and (2) ensuring proposals for significant changes are carefully developed and thoughtfully evaluated with stakeholder input. We recommend HHS not finalize major changes, such as adopting the proposed Exchange direct enrollment (DE) model or significant changes to the risk adjustment model at this time to allow additional time for stakeholder input.

AHIP's comments on the Proposed 2022 Payment Notice include the following recommendations:

- **Finalize critical information for Plan Year 2022:** HHS should ensure information critical to finalizing 2022 products and rates is finalized in a timely manner to ensure health insurance providers can meet state filing deadlines. For plan year 2022, we recommend the Department ensure the premium adjustment percentage, required contribution percentage, maximum annual limitation on cost-sharing, reduced maximum annual limitation on cost-sharing, and user fees are finalized by late Winter so issuers can complete product offerings and rates for the 2022 plan year and meet Spring state filing deadlines.³
- **Predictable timeline for rulemaking and guidance:** We appreciate the earlier timing for this proposed rule compared to recent years. We strongly support the Department's proposal to issue cost-sharing parameters through sub-regulatory guidance in the preceding January for plan years 2023 and onward. Likewise, we urge the Department to issue proposed rulemaking on this earlier schedule to provide more time for the HHS to consider comments and finalize new requirements or changes and provide issuers needed time to incorporate changes in their products and rates for the upcoming plan year.
- **Proposed Exchange Direct Enrollment option:** Americans seeking coverage and financial assistance should be assured an accurate, reliable, easy-to-use eligibility and enrollment experience. The Department proposes a new Exchange direct enrollment (DE) option to allow states to move away from a centralized Exchange website and rely instead on third party websites to support plan shopping, eligibility determinations, plan selection, and enrollment. Such a proposal would fundamentally overhaul the Exchange framework in states that choose to adopt it. We are concerned a decentralized Exchange model could have negative consequences for consumers, undermining the streamlined eligibility and enrollment process and "no wrong door" approach HHS and issuers have implemented. We strongly urge the Department to not finalize this proposal at this time. We instead recommend this proposal is more carefully evaluated and developed in greater detail before being re-proposed in future rulemaking.
- **Risk Adjustment:** We appreciate the challenges the Department faces when evaluating various options for updating the risk adjustment model and the risk adjustment data validation (RADV) process. For significant changes to the risk adjustment model, like those proposed in the 2022 Payment Notice, HHS should engage a white paper process to allow for stakeholder input and more in-depth vetting and analysis of potential changes before they are formally proposed. For example, while the Payment Notice includes discussion of the Department's goal of addressing predictive accuracy for enrollees with no hierarchical condition categories (HCCs) as well as the

³ Rate filing deadlines vary by state. The earliest states require rate submissions beginning May 1. State binder filing deadlines begin as early as March.

December 29, 2020

sickest enrollees, the proposal to combine a two-stage specification approach with interacted HCC count factors had not been vetted previously. Further, comment deadlines do not allow for enough time to adequately evaluate potential unintended consequences of these significant updates. A white paper process, like the process to update RADV, would address some of these concerns. We believe this same process should be used when addressing updates to the existing elements (e.g., enrollment duration factors), as well as when considering future updates to reflect emerging trends in treatment and therapy patterns.

- **User Fees:** We appreciate the Department’s proposal to reduce the user fee for issuers in states using healthcare.gov. We anticipate the proposed user fee rate for plan year 2022 will not reduce the total funds collected below that of recent years and, therefore, should not adversely impact Exchange operations. We strongly encourage HHS to increase the budget for marketing, outreach, and education to promote robust enrollment. For future years, we support the adoption of a per capita user fee so the user fee is not tied to premium growth.
- **Special Enrollment Periods (SEPs):** We appreciate the Department’s proposals to address certain gaps in existing SEP rules or qualifying events, specifically those to address scenarios faced by consumers who lost coverage or had a change in income making them newly eligible for coverage or subsidies as a result of the COVID pandemic and resulting economic crisis. We support adopting these targeted modifications to SEP qualifying events, with guardrails like SEP verification.

We provide detailed comments on these and other provisions of the proposed rule in our attachment.

We appreciate the opportunity to offer comments on the proposed 2022 Payment Notice. We are committed to working with the Department on policies that ensure high-quality and affordable health insurance options are available for Americans.

Sincerely,



Jeanette Thornton
Senior Vice President, Product, Employer, and Commercial Policy



Kelley Schultz
Executive Director, Commercial Policy

Attachment

AHIP Comments on 2022 Payment Notice Proposed Rule

AHIP's comments on the proposed rule are organized in the following sections:

- I. Exchange Direct Enrollment Option
- II. State Innovation Waivers (31 CFR Part 33 and 45 CFR Part 155)
- III. Risk Adjustment and RADV
- IV. Special Enrollment Periods
- V. Prescription Drug Reporting Requirements
- VI. Cost-Sharing Parameters
- VII. Other Exchange Establishment Standards (Part 155)
- VIII. Other Health Insurance Issuer Standards (Part 156)
- IX. Medical Loss Ratio (Part 158)

I. Exchange Direct Enrollment Option (§155.221(j))

HHS proposes to allow states to opt into an Exchange Direct Enrollment (DE) model, which would allow the state to transition from a centralized exchange website to third party enrollment websites. If finalized, state-based exchanges (SBEs) could elect the SBE-DE option beginning plan year 2022 and current Federally-facilitated Exchange (FFE) and State-based Exchanges using the Federal Platform (SBE-FP) states could elect the FFE-DE or SBE-FP-DE option, respectively, beginning in plan year 2023.

Recommendations:

- **Consumers in all states should have access to reliable, accurate, consistent information when comparing coverage options, seeking an eligibility determination, and enrolling in a qualified health plan (QHP) through the Exchange.** The Affordable Care Act (ACA) created a framework whereby consumers access a centralized website to compare coverage options, compare information on benefits, costs (net subsidies, if applicable), and quality ratings for all available QHPs, seek an eligibility determination, and enroll in coverage. Providing all QHP information so consumers can compare apples-to-apples options and performing end-to-end eligibility and enrollment functions through a centralized website ensures a seamless and reliable experience for consumers. HHS has worked to build the healthcare.gov brand just as states have worked to build their Exchange brands. Recognition of a centralized Exchange website is a key factor in building consumer awareness around the availability of coverage, how and where to seek information on QHPs and subsidies, and key dates such as annual open enrollment periods. This consumer awareness and trust are critical to expanding coverage. We are concerned a decentralized Exchange framework, without a single one-stop shopping website could erode that consumer awareness and trust.
- **The Enhanced DE (EDE) program is an important tool to provide consumers options to shop for and enroll in coverage in addition to centralized Exchange websites.** Enhanced DE provides consumers the option to shop for QHPs, receive a determination of eligibility to enroll in

coverage through the Exchange and receive subsidies, and enroll in coverage through a seamless experience on non-Exchange websites offered by QHP issuers or web-brokers. HHS has collaborated with industry for years to conceptualize an improved DE experience, develop the EDE model, design program requirements, and successfully implement EDE websites. AHIP and our member QHP issuers are committed to continuing to work with HHS to further strengthen this program with the goal of ensuring all doors to Exchange coverage provide consumers with a reliable, impartial, end-to-end eligibility and enrollment experience. EDE websites add value by providing an additional pathway for enrollment through a no-wrong-door approach. Conversely, we are concerned the proposed Exchange DE option would take away enrollment options.

- **We recommend the Department not adopt an Exchange DE model.** The proposed shift away from a centralized Exchange website could fundamentally overhaul the Exchange shopping and enrollment framework, raising a litany of questions related to consumer experience, operations, and impact for the risk pool. We recommend HHS first work with stakeholders to further explore the potential advantages or consequences of shifting to such a model, conduct consumer focus groups, account for operations considerations, and conduct an assessment of the potential impact for enrollment and premiums. We understand the technology investment for states to build and maintain Exchange websites is significant and states may be interested in leveraging technology or a platform developed by the private sector. Such proposals need to be more thoroughly vetted, with extensive discussion of consumer-facing impacts and operational details before determining whether a viable solution could help states better meet, rather than undermine the ACA's goals for reliable, accurate, easy-to-use Exchange websites. If this option remains a priority for the Department, we recommend HHS propose a more detailed plan through future notice and comment rulemaking.

II. State Innovation Waivers (31 CFR Part 33 and 45 CFR Part 155)

A. Section 1332 Application Procedures (31 CFR 33.108 and 45 CFR 155.1308), Monitoring and Compliance (31 CFR 33.120 and 45 CFR 155.1320), and Periodic Evaluation Requirements (31 CFR 33.128 and 45 CFR 155.1328)

The Departments propose to incorporate the 2018 State Relief and Empowerment Guidance in full in the regulations at 31 CFR 155.1320 and 45 CFR 155.1320 to provide certainty for states regarding how the Departments will evaluate and review section 1332 waiver programs.⁴

In our comments in response to the 2018 guidance we supported state flexibility generally, but articulated concerns about the suggestion in the guidance that pass-through funding might be made available to subsidize the purchase of products that do not qualify as individual market health insurance under federal law.⁵ We agree provisions for approving 1332 waivers should be codified into regulation and undergo the comment process required under the Administrative Procedures Act to provide certainty to states. However, we are concerned with the specific provisions in the 2018 guidance related to guardrails and do not support codifying those guidelines.

Recommendation:

- **Do not finalize the proposal to incorporate the 2018 State Relief and Empowerment Guidance into regulation.** The guardrails articulated in the 2018 guidance allow for the approval of waivers likely to drive up premiums for comprehensive coverage subject to ACA pre-existing

⁴ <https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers>

⁵ See AHIP Comments on Guidance for Section 1332 State Innovation Waivers, December 20, 2018. Available in full at <https://www.ahip.org/ahip-submits-comments-on-guidance-for-section-1332-state-innovation-waivers/>

condition protections. This could make coverage unaffordable for people with pre-existing conditions. Our detailed comments on the 2018 guidance provide additional information on these concerns.

III. Risk Adjustment and RADV (Part 153)

We appreciate the consideration by HHS of updating the risk adjustment model and the data validation process to ensure the program works as intended. In addition to our comments and recommendations in response to specific proposals in the proposed rule, we provide the following general comments:

- **Risk adjustment should be about mitigating adverse selection while providing incentives for issuers to improve their enrollee's health.** The goal of the ACA risk adjustment program is to compensate health insurers for the health mix in the populations they enroll so premiums reflect differences in coverage/plan factors and not individual health status. Model updates that focus on greater precision for low-frequency, high-cost, acute multi-hierarchical condition categories (HCC) events mean a reduction in the precision where risk adjustment needs it most – chronic conditions and other predictable costs.
- **Risk adjustment data validation (RADV) should be focused on transfer accuracy.** The process is intended to validate the accuracy of data submitted by insurers to ensure risk adjustment transfers reflect actual risk.
- **Model updates need to consider new therapies and treatments that may not be reflected in prior year EDGE claims data.** In 2016, HHS sought to include prescription drugs in the risk adjustment methodology, believing drug utilization could provide more accurate information about the health status of enrollees and help to more precisely identify severity of cases among the same health condition. As new therapies and treatments emerge (e.g., gene therapies), HHS should consider options to ensure the model adequately reflects selection risk. We strongly recommend HHS convene a stakeholder process to work on potential solutions now to ensure long-term market stability.
- **Significant changes to the risk adjustment program should be assessed and developed through a stakeholder and white paper process before being proposed in notice-and-comment rulemaking.** The Department proposes several changes that could have a significant impact on the risk adjustment model. The 30-day comment period for the annual Payment Notice is insufficient for stakeholders to conduct a thorough, data-driven analysis of the potential changes and provide comprehensive feedback. We strongly encourage HHS to engage stakeholders in listening sessions and a white paper process to thoroughly explore proposed changes and work collaboratively to develop proposed changes before proposing through rulemaking.

A. HHS Risk Adjustment (§153.320)

Updates to Data Used for Risk Adjustment Model Recalibration

The Department proposes to use 2016, 2017, and 2018 EDGE data, rather than the 2017, 2018, and 2019 data in the 2022 benefit year risk adjustment model. In addition, the Department proposes to continue to use blended coefficients from the three years of risk adjustment models for the 2022 benefit year model recalibration.

Recommendation:

- **AHIP does not support the Department’s proposed approach. Instead, we recommend HHS use the three most recent years of enrollee-level EDGE data (e.g., 2017, 2018, and 2019 data) for the 2022 benefit year risk adjustment model.** As noted in AHIP’s comments on the 2021 Payment Notice, we support recalibrating the model based on the most recent years’ claims experience through enrollee-level EDGE data.⁶ We appreciate the Department’s goal of making the final blended coefficients available earlier and we concur that it would be ideal to have the coefficients finalized earlier in the process. However, having the most recent claims data is more important to the methodology than earlier knowledge of the final coefficients. For example, incorporating changes in medical practice (e.g., new treatments and therapies) into the models is already challenging and the proposed change would exacerbate it.

Risk Adjustment Model Updates

The Department proposes two model updates beginning with the 2022 benefit year to improve predictive accuracy. The first proposed update would modify the risk adjustment model specifications for the adult and child models by combining a two-stage specification and adding HCC counts factors. The two-stage specification would be combined with the severity and transplant indicators from the interacted HCC counts factors. The Department would remove the current severity illness indicators in the adult models beginning with the 2022 benefit year.

Recommendations:

- **HHS should not adopt the proposed updates to the risk adjustment model for the 2022 benefit year.** To adequately evaluate the feasibility of the two-stage specification process combined with interacted HCC counts factors, we believe additional analysis is needed. Consistent with our comments regarding significant changes to the risk adjustment program, we recommend HHS engage stakeholder input and a white paper approach to better explore and solicit input on significant changes to the risk adjustment model.
- **HHS should engage stakeholders in listening sessions and a white paper process (similar to RADV) for development of any significant model updates for the 2023 benefit year and beyond.** We strongly encourage HHS to take a step back and work with stakeholders through listening sessions and/or a white paper process that will allow for consideration and analysis of various updates before they are proposed in the annual Notice of Benefit and Payment Parameters.

Changes to the Enrollment Duration Factors

To improve the predictive ability for partial year enrollees with HCCs, the Department proposes to change the enrollment duration factors (EDFs) in the adult models. Beginning with the 2022 benefit year, the Department proposes to remove the current 11 enrollment duration factors of up to 11 months in the adult models and add new monthly duration factors of up to six months.

Recommendations:

- **HHS should maintain the existing enrollment duration factors for benefit year 2022 and engage stakeholders through listening sessions and a white paper process to update enrollment duration factors for 2023 and beyond.** While the Department’s proposal would address concerns, particularly in the individual market and at shorter enrollment durations, the proposal would not be beneficial for those issuers in the small group market. The individual and

⁶ See AHIP Comments on the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021 Proposed Rule. March 2, 2020. Available at: <https://www.ahip.org/wp-content/uploads/AHIP-2021-NBPP-Proposed-Rule-Comment-Letter.pdf>.

small group markets have different risk profiles, selection dynamics, and patterns of partial-year enrollment (the small group market is more impacted by non-calendar year renewals).

- **We encourage HHS to identify and address differences between the individual and small group markets.** As our members have evaluated the Payment Notice and several of the proposed updates to the risk adjustment model and recalibration, including updates to the EDF, we began to consider ways to address differences between the individual and small group markets. We encourage HHS to identify key issues that separate the two markets from an adverse selection perspective. The Department should explore different enrollment duration factors and consider whether different models for the different markets would be appropriate. EDF is a good example of an issue that could benefit from a segment specific approach, but we believe these stakeholder conversations could go beyond EDF to include other model updates and recalibration.

Pricing Adjustment for the Hepatitis C Drugs

The Department proposes to continue applying the market pricing adjustment to the plan liability associated with Hepatitis C drugs that was implemented for the 2020 benefit year. They will reassess this position in future years.

Recommendation:

- **AHIP supports the continued pricing adjustment for Hepatitis C drugs.** While we continue to support the adjustment, we do encourage HHS to reassess on an ongoing basis to ensure the coefficient not be constrained beyond the expected decrease in the cost of the drugs.

Cost-Sharing Reduction Adjustments

The Department proposes to maintain the CSR factors finalized in the 2019, 2020, and 2021 Payment Notices. Similarly, they propose to continue to use a CSR adjustment factor of 1.12 for all Massachusetts wrap-around plans.

Recommendation:

- **AHIP supports the proposal to maintain the CSR factors to ensure stability for the 2022 plan year.**

B. Audits and Compliance Reviews of Issuers of Reinsurance-eligible Plans (§153.410(d)) and Risk Adjustment Covered Plans (§153.620(c))

Audits and Compliance Reviews of Issuers of Reinsurance-eligible Plans (§153.410(d)) and Risk Adjustment Covered Plans (§153.620(c))

Based on audits of the 2014 benefit year data, the Department is codifying audit requirements and parameters to reduce difficulties in obtaining data from issuers in a usable format. The Department proposes several modifications to clarify audit requirements, mirroring the standards established for compliance review of QHP issuers participating in FFEs.

Recommendations:

- **We recommend HHS maintain audit standards through sub-regulatory guidance to maintain flexibility for unique situations and make it easier to revise requirements as needed to continually improve the process.** Specifically, we recommend the Department adopt the following changes to proposed standards through sub-regulatory guidance:
 - **We oppose the proposed timeline for these targeted audits.** Issuers need more than 15 calendar days advance notice of the Department's intent to conduct an audit and may need

more than 30 calendar days to provide audit data in response to any request. In many cases, the data specifications for these audits are unknown until several years after the data is created and stored. As such, data may not be available in the manner and format the Department requires. To convert data to the requested format may not be feasible either because it is cost prohibitive or could impact data integrity. We recommend the Department incorporates flexibility within the timeframes for responding to data requests, as well as allow for additional extensions, to ensure issuers can work with HHS or its designee to comply with all audit requirements.

- **Rather than requiring data be provided to HHS in a standard format specified by HHS, issuers being audited and HHS should jointly agree upon a data format.** Depending on the type of data being requested and the way data is configured in an issuer's system, issuers may be limited in the format and time period for which they are able to provide data. Data should be submitted in a format and manner mutually agreed upon by HHS and the issuer.

C. EDGE Discrepancy Materiality Threshold

The Department proposes to codify a materiality threshold for EDGE discrepancies—the amount in dispute must equal or exceed \$100,000 or one percent of the total estimated transfer amount (whichever is less). The new materiality threshold would be effective beginning with the 2020 benefit year.

Recommendation:

- **AHIP supports the codification of the EDGE discrepancy materiality threshold.** We appreciate the Department defining the materiality threshold, which has not previously been formally defined.

Timeline for Collection of HHS-RADV Payments and Charges

The Department proposes to release the applicable benefit year's RADV summary report no later than early summer and require issuers to report those amounts in the medical loss ratio (MLR) reports submitted by July 31 of the same calendar year.

Recommendations:

- **We support the Department's proposal to collect RADV charges and disbursement of payments in the calendar year in which RADV results are released.** While we have some concerns with the incorporation of multiple years' adjustments into the 2021 and 2022 MLR reporting years, we agree HHS needs to address the timing for collection of RADV charges and disbursement of payments.
- **We strongly recommend the Department define specific timing for the release of the RADV summary report.** In the proposed rule, HHS proposes to release the applicable benefit year's RADV summary report no later than "early summer." We encourage HHS to designate a date (e.g., May 31 or June 1) by which issuers may expect the report. This would be similar to the Department's publication of the risk adjustment summary report annually no later than June 30. We note that issuers submitting MLR reports generally need the month of July to incorporate the risk adjustment transfer amounts and RADV adjustments. This includes performing quality assurance and other checks to ensure that the MLR reports themselves are complete and accurate by July 31.

Second Validation Audit and Error Rate Discrepancy Reporting Windows

Current regulations allow issuers 30 calendar days to confirm or dispute the findings of the second validation audit or the calculation of the risk score error rate. The Department proposes to shorten the

window to confirm the findings to within 15 calendar days of the notification by HHS beginning with the 2020 benefit year RADV.

Recommendation:

- **We oppose the proposal to shorten the window to confirm or dispute second validation audit findings.** Our members prefer to retain the existing 30-day timeframe. The proposed 15-day timeline does not provide adequate time to complete a thorough review.

IV. Special Enrollment Periods

A. Special Enrollment Periods (§155.420)

HHS proposes to (1) allow current enrollees who become newly ineligible for APTC to enroll in a QHP at a lower metal level; (2) provide a new SEP for individuals, enrollees, or dependent who did not receive timely notice of a triggering event or was unaware a triggering event occurred; and (3) clarify complete cessation of employer contributions for COBRA is a qualifying event.

Recommendations:

- **SEPs should provide Americans an opportunity to access coverage when their circumstances change without undermining the stability of the individual market risk pool.** The COVID-19 pandemic and related economic consequences resulted in millions of Americans becoming unemployed, losing income, or losing health insurance coverage. Most life events that should result in an individual becoming newly eligible for Exchange coverage or subsidies are addressed by existing SEPs. However, the COVID-19 public health emergency revealed gaps in the existing Exchange rules that made it difficult for some Americans to access coverage or subsidies when faced with a public health and economic crisis. We support targeted changes proposed by the Department to ensure Americans can access affordable coverage when they are at their most vulnerable.
- **We support allowing existing Exchange enrollees who become newly ineligible for APTC to enroll in a new QHP at a lower metal level.** The proposed change would align with existing scenarios in which enrollees are exempt from metal level restrictions to provide enrollees an opportunity to switch to coverage with a lower premium. We agree with the Departments that enrollees should be educated on the potential impacts to their overall out-of-pocket costs if they enroll in a new QHP, such as the impact of resetting accumulators.
- **We recommend the Department limit the scope of the “untimely notice” SEP to scenarios where an employer fails to provide timely notice of termination of coverage (when state continuation protections do not apply) to reduce opportunities for gaming.** The proposed “untimely notice” qualifying event as drafted could be overly broad and subjective, which increases risk that it could be subject to fraud and abuse. HHS illustrates two examples in which an individual is unaware of a qualifying event or receives untimely notice—(1) individuals enrolled in employer-sponsored coverage who did not receive notification from their employer when the employer ceased making premium payments; and (2) when technical errors block an individual from enrolling in coverage. We recommend HHS only adopt the first scenario when employers fail to provide timely notice of termination of coverage to plan participants. The second scenario, when technical errors block an individual from enrolling, should be addressed by the existing Exchange error SEP. We recommend the Exchange require documentation of the date the employee received notice from the employer to verify eligibility. This SEP should be implemented with a prospective effective date. We do not support retroactive effective dates.

- **We support clarifying complete cessation of employer contributions to COBRA is a qualifying event for SEP eligibility.** When millions of Americans lost employer-sponsored coverage due to COVID-19, there was not a consistent understanding of the impact of enrolling in, and later losing, subsidized COBRA on eligibility for Marketplace coverage. We appreciate the clarification that cessation of employer contributions to COBRA is a qualifying event.

B. SEP Verification (§155.420)

The Department proposes to require that all Exchanges conduct eligibility verification for at least 75 percent of new enrollments through SEPs for new enrollees not already enrolled in Exchange coverage. HHS proposes to provide Exchanges until plan year 2024 to implement SEP verification.

Recommendation:

- **We support requiring all Exchanges, including SBEs, to verify eligibility for at least 75 percent of new SEP enrollments.** Currently, all Exchanges that use healthcare.gov and most SBEs verify at least 75 percent of enrolling consumers newly enrolling in coverage through an SEP. HHS notes in the preamble that four states—Maryland, District of Columbia, Rhode Island, and Vermont—only verify one SEP type, which represents about 60 percent of all SEP enrollments across those states. We support requiring that all Exchanges verify at least 75 percent of new SEP enrollments to promote program integrity across all states.

V. Prescription Drug Reporting Requirements

A. Prescription Drug Distribution and Cost Reporting by QHP Issuers (§156.295)

Section 1150A(a)(2) of the Public Health Service Act (PHSA) requires a pharmacy benefit manager (PBM) under a contract with a Medicare Part D plan sponsor or Medicare Advantage plan that offers a Medicare Part D plan, or with a QHP offered through an Exchange, to provide certain prescription drug information to the Secretary. These requirements were previously codified in the 2012 Exchange Rule. In January and September of 2020, the Department published notices and comment opportunities on information collection requests under the Paperwork Reduction Act for data collection from PBMs regarding QHPs under section 1150A(a)(2).

QHP Issuer Responsibilities

The Department proposes to revise §156.295(a) to state where a QHP issuer does not contract with a PBM to administer the prescription drug benefit for QHPs, the QHP issuer will report the data required by section 1150A. HHS proposes corresponding revisions throughout §156.295 to remove the applicability of the reporting requirement for PBMs under this section and propose revising the title to “Prescription drug distribution and cost reporting by QHP issuers.” The Department further proposes to remove a requirement that a QHP that does not contract with a PBM must report spread pricing because spread pricing is a feature only present when a PBM is involved in the administration of drug benefits. Under the proposed regulation, where a QHP contracts with a PBM, the Department proposes the PBM is responsible for reporting data.

Reporting of Data by Pharmacy Type

Section 1150A(b)(1) of the statute requires data to be reported by “pharmacy type.” For Medicare reporting requirements under this statute, the Department already recognized pharmacy type is not a standard classification currently captured in industry data and it is not possible to report by pharmacy type. For the same reasons, the Department proposes to revise §156.295(a)(1) to remove the requirement to report for QHPs by pharmacy type.

Recommendations:

- **We support the proposed requirement for the QHP to report if the QHP does not contract with a PBM.**
- **We agree it is currently impossible to report by pharmacy type and this data should not be required in the data collection.**
- **We recommend QHP reporting under Section 1150A begin no sooner than for the 2022 plan year, if these requirements are finalized by early 2021.** QHPs will need to update contracts with PBMs to reflect the new final requirements before the first plan year to be reported. If the requirements aren't finalized in time to update contracts for the 2022 plan year, the first year of reporting should be a later plan year.
- **Reporting should be required at the HIOS issuer ID level, not the HIOS plan ID and National Drug Code (NDC) levels as proposed in the information collection request published in the Federal Register on September 11, 2020.**⁷ The Department is bound by section 1150A, as further detailed in 45 CFR 156.295, which only permits aggregate amount level reporting at the QHP issuer level. As we explained in detail in our comment letter in response to the September 11, 2020, information collection request, HIOS plan ID and NDC level reporting cannot be appropriately construed as aggregate level reporting.

B. Prescription Drug Distribution and Cost Reporting by PBMs (§§ 184.10 and 184.50)

The Department proposes to add part 184 to 45 CFR subchapter E to codify in regulation the statutory requirement that PBMs under contract with QHP issuers report the data described at section 1150A(b) of the Act to the Secretary and to each QHP for which the PBM administers the prescription drug benefit.

Recommendation:

- **We support the proposed change to require PBMs to report when the QHP contracts with a PBM.**

VI. Other Exchange Establishment Standards (Part 155)

A. Consumer Assistance Tools and Programs of an Exchange (§155.205)

The Departments propose a QHP issuer or a web-broker participating in the FFE enhanced direct enrollment (EDE) program would have 12 months from the date it begins operating its EDE website in a state to translate website content into any non-English language that is spoken by a limited English proficient (LEP) population that comprises at least 10 percent of the total population of the relevant state.

Recommendation:

- **We support the proposed flexibility to allow EDE partners additional time to come into compliance with website content translation requirements in a state where a non-English language is spoken by an LEP population comprising at least 10 percent of the total state population.** In states where LEP populations exceed the 10 percent threshold, providing additional time for website translation of certain content may help lower the burden of participating as an EDE partner.

⁷ 85 Fed Reg 56,227

B. Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§155.220)

Navigator and Certified Application Counselor (CAC) Use of Web-broker Websites

Existing rules prohibit navigators and CACs (“assisters”) from using web-broker websites to assist consumers with QHP selection and enrollment. The Department, citing expanded EDE functionality and increased use of the EDE pathway, proposes to allow assisters in the FFE and SBE-FPs to use web-broker websites for Classic DE or EDE, if certain requirements outlined in the proposed rule are met.

Recommendation:

- **The Department should not finalize the proposal to allow navigators and CACs to use web-broker websites to assist consumers with QHP selection and enrollment.** Assisters are required to provide impartial assistance to individuals seeking coverage through the Exchanges. Web-broker websites are not required to be impartial. While HHS proposes additional requirements that web-broker websites must meet, we remain concerned about the consumer experience that would result if assisters are permitted to use web-broker websites.

QHP Information Display on Web-broker Websites

The Department proposes to adopt new §155.220(n), which would provide flexibility to exempt web-brokers from certain display requirements if a web-broker’s non-Exchange website does not support enrollment of a QHP.

Recommendation:

- **HHS should not adopt flexibility to exempt web-brokers from displaying certain required information if the web-broker website does not support enrollment of a QHP.** In the spirit of the ACA’s goal of “no wrong door,” we believe all websites that support Exchange plan comparison, eligibility determinations, and enrollment should display complete and accurate information on QHPs available in that consumer’s service area. Providing flexibility for certain non-Exchange websites to provide less information undermines this goal and we believe is a disservice to consumers. We recommend web-brokers’ non-Exchange websites should provide all QHP information, regardless of whether the web-broker supports enrollment for a QHP.

C. Standards for Direct Enrollment Entities and for Third Parties to Perform Audits of Direct Enrollment Entities (§155.221)

Direct Enrollment Entity Plan Display Requirements (§155.221(b)(1))

HHS proposes to require that DE entities display and market products with substantially different characteristics—QHPs offered through the Exchange, individual health insurance coverage as defined in §144.103 offered outside the Exchange (including QHPs and non-QHPs other than excepted benefits), and all other products, such as excepted benefits—are displayed on at least three separate website pages. HHS proposes revisions to limit marketing of non-QHPs during the Exchange eligibility application and QHP selection process.

Recommendation:

- **We support requirements to ensure consumers understand the coverage options available to them, including the availability of subsidies, and the plan they are enrolling in. We agree these are the minimum guardrails HHS should adopt to minimize opportunities for consumers seeking coverage through the Exchange to be intentionally or inadvertently steered toward a non-QHP or non-subsidized QHP when shopping on a DE website.** Non-Exchange websites should be held to high standards to ensure consumers seeking an eligibility determination for subsidies or to enroll in a QHP offered through the Exchange have a similar

experience as if they enrolled directly through healthcare.gov. Guardrails should limit opportunities for a consumer to accidentally enrolled in or be steered toward a non-subsidized QHP or non-QHP. At minimum, substantially different coverage types should be listed on separate website pages, as proposed, to ensure consumers compare apples-to-apples products. These website pages should clearly describe the type of coverage a consumer can shop for on that page (e.g., on- versus off-Exchange, whether subsidies are available, whether products offer comprehensive coverage). We further support a prohibition on marketing non-QHPs during the Exchange eligibility application and shopping process to avoid practices that could steer consumers toward a product that does not offer subsidies or provides less robust coverage.

VII. Other Health Insurance Issuer Standards (Part 156)

A. User Fee Rates for the 2022 Benefit Year (§156.50)

FFE and SBE-FP User Fee Rates for the 2022 Benefit Year (§156.50(c))

The Departments propose to lower the user fee rates for issuers participating in FFEs and SBE-FPs. For the 2022 plan year, HHS proposes a user fee for issuers in the FFE of 2.25 percent of monthly premiums, a decrease from the 3.0 percent user fee in the 2020 and 2021 plan years. The proposed 2022 user fee rate for issuers offering QHPs through SBE-FPs is 1.75 percent of premiums, a decrease from the 2.5 percent user fee rate for the 2021 plan year.

Recommendation:

- **We appreciate the proposed reduction in user fee rates for issuers in states that use healthcare.gov and recommend user fees are finalized as proposed for plan year 2022.** As HHS acknowledges in the preamble, costs to operate healthcare.gov in year seven should not require the same budget as in early years. As the administrative functions of the Exchange evolve, it is appropriate to reduce the total user fees collected to support healthcare.gov operations. We anticipate the proposed reduction would result in total user fees similar to plan years 2016-2017. Since 2017 (the introduction of silver loading to accommodate the loss of CSR funding) premium increases resulted in increased user fees at the same time HHS reduced the budget for marketing and outreach. It is our understanding this has resulted in a healthcare.gov budget surplus in recent years. Total user fee collections aligned with plan years 2016-2017 would be appropriate and allow HHS to support healthcare.gov without undermining Exchange operations. Further, because HHS conducted more robust outreach, education, and marketing for annual open enrollment in those years, we recommend HHS use collected user fees to increase spending on these activities to better support consumers and bolster enrollment.

Eligibility for User Fee Adjustments for Issuers Participating through SBE-FPs (§156.50(d))

Section 156.50(d) allows issuers in FFEs to qualify for an adjustment to the FFE user fee to reflect the value of contraceptive claims they have reimbursed to third-party administrators (TPAs). The Department proposes to amend §156.50(d) to clarify that issuers participating in SBE-FPs are eligible to receive these adjustments, as well as issuers in FFEs and SBEs that adopt the DE option.

Recommendation:

- **We support HHS' clarification that issuers participating in SBE-FPs are eligible to receive user fee adjustments for the value of contraceptive claims reimbursed to TPAs.**

Request for Comments on Alternatives to Exchange User Fees (§156.50)

The Department seeks input on the appropriateness of the current user fee methodology and whether an alternative revenue source to ensure Exchanges can meet costs of operating Exchanges in an appropriate and fair manner.

Recommendations:

- **We appreciate the Department’s interest in reevaluating whether alternative user fee methodology should be adopted to support Exchange operations.** We agree with HHS’ assessment in the preamble that operational costs to operate healthcare.gov in year seven should not be the same as early years. Now is an appropriate time to reassess both the level of funding needed to support healthcare.gov operations as well as the methodology used to assess issuers.
- **We continue to recommend the Department provide greater transparency into the amount of user fees collected from issuers participating in healthcare.gov states and a more detailed accounting of how those funds are currently used to support operations.** While the Department has previously provided high-level information on the healthcare.gov operating budget, more detailed transparency is needed to meaningfully assess the level of funding needed to support Exchange operations and whether an alternative methodology would be more appropriate to achieve those funding needs.
- **For plan year 2023 and beyond, HHS should assess the impact of adopting a capitated user fee.** Currently, healthcare.gov operations are supported by a user fee calculated as a percent of premiums. Under the current approach, user fees rise with medical trend, AV calculation and plan value trend, average enrollee age, overall health of the risk pool, CSR silver loading, and other factors that increase rates. A capitated user fee methodology would instead generate additional funds to support FFE and SBE-FP operations as enrollment increases, creating a new set of enrollment-based incentives.
- **We recommend the Department explore the impact of assessing a lower user fee for issuers who are enhanced DE partners.** Issuers who participate in enhanced DE have made significant investments which also relieve burden on healthcare.gov to conduct eligibility and enrollment and customer service functions. Thus, we believe a lower user fee for EDE issuers would be appropriate.

B. Premium Adjustment Percentage (§ 156.130(e))

The proposed premium adjustment percentage for the 2022 benefit year is 1.4409174688, which represents an increase in private health insurance (excluding Medigap and property and casualty insurance) premiums of approximately 44.1 percent over the period from 2013 to 2021. Beginning with the 2023 benefit year, HHS proposes to publish the premium adjustment percentage and related cost-sharing parameters through guidance by January of the year preceding the applicable benefit year.

Recommendations:

- **For plan year 2022, we recommend HHS finalize the premium adjustment percentage as proposed.** Premium adjustment percentage, maximum annual limitation on cost-sharing, reduced maximum annual limitation on cost-sharing, and required contribution percentage should all be finalized as proposed in a timely manner so issuers can finalize 2022 products and rates. For plan year 2022, if HHS can revert to the previous premium adjustment percentage methodology (discussed below) in a timely manner so that issuers can finalize products and rates ahead of state deadlines, we would support this change.
- **We strongly support publishing guidance to in January of the preceding plan year to update the premium adjustment percentage, required contribution, annual limitations on cost-sharing, and required contribution percentage.** Issuing information on cost-sharing parameters through sub-regulatory guidance on a predictable schedule in January of the preceding plan year will ensure issuers receive critical inputs needed to finalize product design and premium

rates in a timely manner. Issuing this information through the annual Payment Notice is unnecessary, unless significant methodological changes are proposed, and can adversely impact issuers' ability to meet filing state deadlines.

- **For plan year 2023, we recommend the Department revert to the premium adjustment methodology used for plan years prior to 2020 or explore another index to measure premium growth.** For plan years 2014 through 2019, premium adjustment percentage was calculated using average per-enrollee employer-sponsored premiums. The 2020 Payment Notice adopted a change to the methodology to calculate premium adjustment percentage using CMS Office of the Actuary (OACT) estimates of projected private and individual market health insurance measure, excluding Medigap and property and casualty. This has resulted in a faster premium growth rate—increasing the amount of premium individuals owe, decreasing eligibility for premium tax credits, and making it less likely consumers with an offer of employer-sponsored coverage would be eligible for premium tax credit. To promote affordability of coverage and access to tax credits, we recommend the Department revert to calculating premium adjustment percentage based on per enrollee employer-sponsored premiums, as it did for plan years prior to 2020, or assess whether another index would more successfully slow premium and MOOP growth to make coverage more affordable.

C. Oversight of the Administration of the Advance Payments of the Premium Tax Credit, Cost-sharing Reductions, and User Fee Programs (§156.480)

Audits and Compliance Reviews of APTC, CSRs, and User Fees (§156.480(c))

Like proposals related to audits of issuers in reinsurance-eligible plans and risk-adjusted plans, HHS proposes to clarify the issuer requirements for APTC and CSR audits. HHS proposes to codify issuer obligations with respect to these audits, including what it means to comply with an audit and the consequences for failing to comply. HHS proposes to clarify its ability to audit FFE and SBE-FP user fees, which are currently reviewed when conducting APTC standards.

Recommendations:

- **The Department should not codify the proposed requirements for audits and oversight of APTC, CSR, and user fee standards.** It is valuable for both QHP issuers and HHS to have a clear set of expectations for the timing and process of an audit from the outset. However, we are concerned the standards proposed for compliance reviews are overly rigid. Issuers who have undergone APTC and CSR audits in the past have noted they requested and received extensions for certain submissions to ensure they could submit complete and accurate data. Codifying timelines would eliminate the ability for the audit vendor and issuer to work collaboratively throughout the audit.
- **We recommend HHS maintain audit standards through sub-regulatory guidance to maintain flexibility for unique situations and make it easier to revise requirements as needed to continually improve the process.** Specifically, we recommend the Department adopt the following changes to proposed standards through sub-regulatory guidance:
 - **HHS should provide at least 30 calendar days advance notice (not 15 days, as proposed) of its intent to conduct an audit and should allow issuers to designate a point of contact in their organization to receive audit notices.** For example, the Centers for Medicare and Medicaid Services (CMS) Account Manager should reach out to the issuer to identify who (one or multiple points of contact) should receive notices related to the audit. This would help ensure the audit points of contact are current

employees, in the office, and able to facilitate the audit process. Further, we recommend HHS not initiate new audits during annual open enrollment when plan resources are focused on supporting consumers and completing enrollments.

- **Rather than requiring data be provided to HHS in a format specified by HHS or its vendors, issuers being audited, HHS, and its vendors should work together to leverage existing standardized reporting formats or identify ways to repurpose internal reporting formats.** Depending on the type of data being requested and the way data is configured in an issuer's system, issuers may be limited in the format and time period for which they are able to provide data. Data should be submitted in a format and manner consistent with industry and HHS practice.
- **HHS should provide flexibility, rather than establishing a rigid 30-day deadline, for submission of data.** Given the volume of data and complexities in extracting data from issuers' systems, a 30-day deadline for submissions is unreasonable. HHS should provide flexibility for the auditor to allow more than 30 days when warranted. We recommend the time period be 30 days or as mutually agreed upon by the parties.

D. Quality Rating System (§156.1120)

HHS continues to assess potential refinements to the quality rating system (QRS) rating methodology and QHP Enrollee Survey to improve value for consumers and reduce reporting burdens. Based on feedback from the 2020 QRS and QHP Enrollee Survey Call Letter process, HHS is seeking comment on the which level(s) of the QRS hierarchy should be removed.

Recommendations:

- **We support the Department's efforts to refine the QRS rating methodology and recommend HHS remove the composite and domain scoring levels.** We agree with the need for great stability year over year to support consumer choice and plan quality improvement efforts and agree the QRS should be designed to provide valid and reliable information to help consumers distinguish among QHPs based on performance and quality.
- **We support consolidation of the QRS hierarchy, removal of the composite and domain scoring levels, and applying explicit weights to measures in the QRS.** We have previously raised concerns regarding the unequal implicit weighting inadvertently created by QRS domains and composites. Under the current QRS rating methodology, composites scores are calculated based on the average standardized score of the measures within the composite. The contribution of each measure score to the composite score is weighted by the number of measures within a composite. The fewer measures within a composite, the greater the contribution of the measure to the overall rating. The same rationale applies to the calculation of domain scores from composite scores. The contribution of each composite score to the domain score is weighted by the number of composites within a domain. The fewer composites within a domain, the greater the contribution of the composite to the overall rating. This further amplifies the contribution of individual measures to the overall rating. The result is certain measures end up contributing significantly more to the overall rating due purely to their location within the hierarchy. Using explicit weights allows greater transparency as HHS considers how to design the program to best serve its purpose.
- We recognize the challenges to developing a scoring mechanism that supports the varied purposes of the QRS and note that a stepwise approach may be needed to implement solutions. If a short-term solution is needed, we would recommend HHS prioritize removing the domain

scores and applying an explicit weighting methodology. Removing the domain scores would provide greater stability to the scores while applying explicit weights would ensure a single measure does not exert disproportionate influence on the global score.

- In the longer term, we recommend HHS consider ways to ensure the methodology supports consumer choice and considers the unique needs of the marketplace population and significant regional variation. If the QRS is presented to consumers as a measure of value, then a one-size fits-all approach is inappropriate. Regional differences in state law and practice, like involuntary hospitalization for mental health, or differences in demographics, like the percent of child enrollees in a state, may result in scores that have more to do with the state than the insurer. Even if QRS is intended to improve issuer performance, this incentive is undermined when the result does not properly measure the plan or how well it works for that specific enrollee.
- **While considering the scoring of the QRS, we ask HHS to consider other opportunities to strengthen the QRS program.** We ask the Department to continue to consider the impact of COVID-19 on performance and data collection. AHIP appreciates the Department's efforts to mitigate the effects of the pandemic on measure results and would recommend HHS continue to evaluate the impacts of COVID-19 on requirements for the 2021 QRS and QHP Enrollee Survey.
- **We recommend HHS continue to consider revisions to the QRS clustering and cut point methodologies to provide more year-to-year stability.** Greater stability will ensure the ratings provide consumers with meaningful information about quality of care. However, we feel HHS should make detailed analyses of any potential approaches publicly available for review and comment before recommending a revised methodology for implementation. This will ensure our recommendations are based on sound statistical evidence and not result in unintended consequences for health plans based on plan size, location, characteristics of their member population, metal tier, or number of available plans in their market. The analysis should include details on how the calculations were conducted for each approach, how the approach differs from the current approach (e.g., the degree of change in a health plan's rating and distribution of ratings), and the impact of other potential refinements such as removing levels of the QRS hierarchy. HHS should work closely with AHIP and its members to review these analyses, allowing us to provide recommendations prior to any change being formally proposed.
- **We recommend the Department continue to examine the impact of beneficiaries' social risk factors and plan metal tiers on QRS performance.** We recommend HHS analyze the impact of (1) social and demographic factors and (2) plan metal tier levels (Gold, Silver, Bronze) on QRS measure results, QHP survey responses, scores at each level of the hierarchy, and star ratings; and publicly report the results for stakeholders to review. We recognize that recent work by the National Quality Forum has shown the impact of the limited availability of data on social risk on adjusting measures for these factors and suggest that the Department could look to the Exchange as a source of member demographic information. We recommend that HHS coordinate between Exchange and QRS to capture any social or demographic factors, rather than adding questions to the Survey or asking the insurer to collect information that is already on the 834 enrollment file.
- **We recommend HHS continue to explore opportunities to align the QRS measure set with measure sets used in other programs (e.g., Medicare Advantage, NCQA Ratings, Medicaid Core Sets, Core Quality Measures Collaborative (CQMC) Core Measure Sets).** Measures retired from HEDIS or retired in other programs (e.g., Medicare) should be removed from the QRS.

E. Enrollee Satisfaction Survey System (§156.1125)

HHS proposes to make the full QHP Enrollee Survey results publicly available in an annual Public Use File (PUF), like the QRS PUFs published every year. Beginning with the 2021 QHP Enrollee Survey results and during the 2022 open enrollment period, the Enrollee Survey PUF would include the score and proportion of responses (for example, the percentage of respondents answering “Never” or “Sometimes”) for every survey question and composite as well as demographic information such as employment status, race and ethnicity, and age at the reporting unit and national level to facilitate data transparency.

Recommendations:

- **For the 2021 QHP Enrollee Survey results and during the 2022 open enrollment period, we do not recommend the Department make the full QHP Enrollee Survey results publicly available in an annual Public Use File (PUF).**
- **While we support efforts to increase transparency and facilitate research to improve the Quality Rating System, we do not support making full results of the QHP Enrollee Experience Survey (EES) publicly available at this time.** AHIP remains concerned about the reliability of the EES and about the inherent low denominator of the survey data. We note the EES is significantly longer than the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0 and Medicare Advantage and Part D (MA-PD) CAHPS surveys. The current survey length is burdensome for survey respondents, which can result in lower response or completion rates, and subsequently can decrease the accuracy and reliability of survey results.
- **We recommend HHS consider removing certain questions with reliability below 0.7 and questions outside of the health plan’s control.** Specifically, we request the Department consider removing the following items due to low reliability: *Question 39* In the last 6 months, how often did you get the help you needed from your personal doctor’s office to manage your care among these different providers and services? (reliability score=0.24), *Question 10* In the last 6 months, how often did the health plan explain the purpose of a form before you filled it out? (Reliability score=0.41), *Question 12* In the last 6 months, how often were the forms that you had to fill out available in the format you needed, such as large print or braille? (Reliability score=0.47), *Question 31* In the last 6 months, how often did your personal doctor show respect for what you had to say? (Reliability score=0.53).

AHIP recommends HHS remove items that may unfairly conflate the role of the provider and the role of the health plan. Specifically, we request the Department consider removing the following items as they are not within the health plan’s locus of control and plans have little ability to influence: *Question 29* In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?, *Question 30* In the last 6 months, how often did your personal doctor listen carefully to you?, *Question 32* In the last 6 months, how often did your personal doctor spend enough time with you?, *Question 37* In the last 6 months, did you get care from more than one kind of health care provider or use more than one kind of health care service?

The Department should consider removing the demographic items from the EES that duplicate information submitted at enrollment and rely on the 834 enrollment file instead. Removing these items would decrease respondent burden and improve the reliability of the data as enrollees will provide more accurate and consistent information about language, race, and income at enrollment. We recommend HHS consider the impacts of utilization on the EES as well as appropriate survey timing. Surveying members in February when they just purchased coverage in January may not result in an accurate reflection of health plan quality or consumer satisfaction.

- **If HHS does choose to release the full survey results publicly, we offer additional recommendations.** The Department should not report survey results with reliability less than 0.7. In addition, HHS should eliminate any survey questions with less than 100 responses in the denominator from reporting, similar to the NCQA reporting requirements. To ensure the accuracy and reliability of information provided to the public, AHIP recommends the Department complete its' review of the EES items outlined in the Draft 2020 Call Letter for the QRS and QHP Enrollee Experience Survey and removes items with low reliability or are outside the health plan's control before publicly reporting full results of the EES.

F. Dispute of HHS Payment and Collections Reports (§156.1210)

HHS proposes to establish a process for issuers to report enrollment or payment data changes in scenarios where data inaccuracies are identified after the 90-day reporting window (e.g., due to an eligibility appeals notification after the 90-day window), up to three years following the end of the plan year to which the inaccuracy relates.

Recommendation:

- **HHS should adopt the proposed process for reporting enrollment or payment data changes identified after the 90-day reporting window.**

M. Enrollment process for qualified individuals (§156.1240)

The Department proposes new paragraph (a)(3) to require individual market QHP issuers to accept payments on behalf of an enrollee from an individual coverage health reimbursement arrangement (ICHRA) or Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

Recommendation:

- **HHS should not require individual market QHP issuers to accept payments on behalf of an enrollee from an ICHRA or QSEHRA.** Accepting premium payments made on behalf of an enrollee with an HRA should be at the option of the issuer, not required by HHS.

VIII. Medical Loss Ratio (Part 158)

A. Definitions (§158.103)

In this proposed rule, the Department proposes to establish the definition of prescription drug rebates and other price concessions for new MLR reporting elements.

Recommendations:

- **Exclude coupons and other items that do not yield reductions in the issuer's prescription drug costs from the definition of prescription drug rebates and other price concessions.** Items such as coupons that are provided to enrollees by third parties do not yield actual reductions in total plan cost and therefore should not be considered price concessions that are deducted from the incurred costs under the MLR program. Similarly, cash discounts, free goods contingent on a purchase agreement, and goods in kind also directly benefit enrollees at the point-of-sale without reducing the issuer's expenses.
- **Update the definition of "bona fide service fees" to be excluded from price concessions to remove the specific reference to "drug manufacturers" and to make it clear that payments for quality improvement activities, along with other services --specifically listed in section 1150A of the Act as "bona fide service fees"-- are considered bona fide service fees.** Update the definition to specify that bona fide service fees include, but are not limited to, the fees specified in Section 1150A(b)(2) of the Act as being bona fide service fees, namely, distribution

service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements. Regarding quality improvement, the Department should very clearly exclude from the definition of price concessions all bona fide services fee payments for services related to quality improvement activities, including drug utilization review, utilization management activities, adherence programs, and other clinical programs that are designed to improve the safety and health of enrollees and reduce fraud, waste and abuse. Finally, these fees could be received from entities other than drug manufacturers, such as drug wholesalers or retail pharmacies and the reference to “drug manufacturers” should be removed.

- **Remove the reference to the term, “direct and indirect remuneration.”** This term that originated in the Medicare Part D program and is not applicable for this purpose. The MLR reporting requirement applicable to commercial issuers (158.140) differs from the MLR reporting requirement for Part D. The commercial requirement refers only to “prescription drug rebates and other price concessions.” It does not include “direct and indirect remuneration” in the requirement as the MLR requirement for Part D plans does.

This term is already defined in 45 CFR 153.500 for risk corridors as “prescription drug rebates received by a QHP issuer within the meaning of §158.140(b)(1)(i) of this subchapter.” Thus, it is already defined and limited to “prescription drug rebates received by a QHP issuer.” It cannot be broadened to include items other than “prescription drug rebates” without additional rulemaking.

- **Remove the word “receivable,” and replace it with “received and retained” to be consistent with 158.140.**