Ref: 2021-28317 CMS Comment Period related to:

CMS-9911-P | Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023

AGENCY: Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information & Insurance Oversight(CCIIO), and HHS.

Dear Secretary Becerra, Deputy Director Wu, and the entire staff involved with research and development of this proposal,

We would first like to say thank you for your efforts to address the needs of the broad market the PPACA looks to serve. This document addresses a request for comments on the provisions proposed to either be adopted, altered, or removed from current policy governing the PPACA.

FULL DISCLOSURE

Currently we sit on the CMS Alpha Broker Workgroup, Pennie (Pennsylvania's Exchange) Policy and Legal Workgroup as an outside voice for the consumers in the markets we serve. At the trade level we sit on the Strategic Development committee for the Central Pennsylvania Business Group on Health as well as have active seats as the legislative chair for the Central Pennsylvania chapter of the National Association of Health Underwriters(nahu.org) and the Pennsylvania State Level Chair for the Health Agents for America(hafamerica.org).

Any and all comments are expressly those of the writer and should not be construed as coming from any of the above organizations, nor should they be used as precedent for future litigation. Our goal with today's comments is to be general in nature and to offer potential considerations as future frameworks are adopted.

OUR WHY

Many of the best organizations are founded based on personal events, and PA Health Advocates (PAHA) is no exception. Founder and Principal, Joshua Brooker received a big surprise along with the birth of his first child. The insurers double billed him on the premise his oldest son was born in a different plan year (1/1) than his mother was admitted (12/31). Out of frustration, and lack of advocacy, PAHA was formed. With more than 10 years in the industry, serving the group, individual, and Medicare markets, PAHA is focused on making things much less complicated and advocating for our clients. We are focused on helping consumers sidestep common pitfalls and assist in claims advocacy when things just are not working right. Additionally, in 2020 we create a separate entity, Helping Health, Inc. as a 501(c)(3) nonprofit to serve constituents at the height of covid with "Application to Approval" support to help consumers navigate CHIP and Medicaid. Finally, we are raising funds for a digital system, SnapHealth, to address the next phase of healthcare regarding SDOH, Interoperability, Health Literacy, and Price Transparency initiatives.

SUMMARY OF TOPICS

This comment will focus on the following topics:

- Definition of "Large group market"
- Past Due Premiums
- Sexual Orientation and Gender Discrimination
- HHS additional QHP data points at enrollee level
- Web-Broker Ethics
- Recommendation Methodology disclosure
- Agent liability for income projection
- Agent/Broker/Web-broker input compliance
- Re-Enrollment Mapping Authority
- User fee

Definition of "Large group market"

> "A. Part 144—Requirements Relating to Health Insurance Coverage
> 1. DEFINITIONS (§ 144.103)"

Under this section you address the removal of superfluous language. Being that the large group market is jointly governed by statutes within the DOL and the respective State Insurance departments, we do not see an adverse consequence to removing the phrase "unless otherwise provided under state law." under 45 CFR § 144.103.

Past Due Premiums

> "B. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets
> 1. GUARANTEED AVAILABILITY OF COVERAGE (§ 147.104)
> A. PAST-DUE PREMIUMS"

Under this section you discuss the imposed barrier on consumers if they are forced to back pay premiums due to an insurer, or for insurers to garnish current premiums to recoup past due premiums.

Background: Under the current interpretation of section 2702 of the PHS act and 45 CFR § 147.104 if an individual in the exchange were to lose coverage due to non-payment of premiums on an ACTIVE policy(not to include a binder payment) then any future attempt to enroll in the same carrier again would be first met with a requirement to satisfy the prior premium due before being eligible to enroll in a plan. Additionally, if you do enroll, say during the PY OEP then insurers have authority to apply your binder payment for the new coverage to satisfy the outstanding balance due.

From reading the article, my understanding is your rationale addresses the current interpretation was to protect insurers from adverse selection in which individuals who may decide to not pay for a period of coverage. For example, they do not pay December coverage, but instead skip a payment, remain covered, and tether the insurer to any medical claims submitted.

We agree, in general, missed premiums are not done with malicious intent. Consumers who want to be covered by a plan want to be covered year-round. Additionally, consumers facing catastrophic events which cause medical bills to exceed OOPM in a plan year are more apt to pay premiums for fear of the repercussions should their plan lapse. This results in people with high claims having higher retention, and people with low claims creating less risk for insurers.

There are various reasons a premium could be missed… Someone could be hospitalized, effected by an environmental disaster, a victim of crime, hit with an external life event effecting their ability to pay in the short run, or other SDOH events. Each of these risks outweighs the miniscule actuarial risk of someone trying to skip payment for a month. The only word of caution would be QHPs interpretation of the law and how they may factor in 11-month enrollees into inflating the cost of care. Attention should be made to ensure carriers are not inflating premiums, especially in low-income markets, claiming to account for this variability. The net result could inadvertently cause discrimination.

Sexual Orientation and Gender Discrimination

We agree, nobody offering QHPs should discriminate based on sexual orientation or gender identity. As such, we encourage amending § 147.104(e).

HHS additional QHP data points at enrollee level

Under this section you are proposing five additional datapoints would be shared with CMS from insurers. These include Zip Code, Race, Ethnicity, ICHRA, and APTC data. For all enrollments submitted either through the FFM, DE, or EDE Pathways, these datapoints should already be available to CMS via the application flowing through your system. For QHPs in compliance with CMS regulations, I see case studies where this can provide value to policy makers.

1. Off-Exchange
    a. I am uncertain if this is required, but if CMS can round out their datasets by seeing both on and off market enrollments, then data scientists can gauge trends disproportionately affecting sub populations. For instance, if the full dataset were distributed then CMS could identify direct-to-carrier enrollments that may have been eligible for APTC by cross referencing income data. Obviously, for full functionality, additional provisions would have to be proposed and approved by the agency. This would help identify bad actors avoiding APTC enrollments, or captive agents who stick to specific carrier products directly which could be a harm to consumer choice.

2. APTC Matching
    a. This data can help CMS in instances when an 834 is sent to the carrier and the APTC the consumer receives according to the carrier, does not match their eligibility notice.

Web-Broker Ethics

We agree wholly, Web Brokers should not be allowed to "sell" preferred placement of a product based upon compensation, whether this be in the form of higher commissions, bonus structures, or separate "Marketing Fees" carriers may pay for such placement.

For any consumer the methodology should be to:

1. Identify demographics.
2. Calculate income (most common place for consumer errors)
3. Understand how the consumer interacts with the healthcare systems (preferred doctors, ensure drugs are covered, adequate network)
4. Confirm no outlier scenarios (pregnancy, divorce claiming dependents, new employment, MEC considerations, etc.)

These four questions each have their own subset of variables. Bypassing all considerations in favor of compensation is negligent at best, and at worst… detrimental to a household with significant medical needs.

Recommendation Methodology disclosure

Under this section, you referenced a methodology disclosure in your proposal to amend § 155.220. At a very high level we recognize, algorithmically, recommendation models will either be relatively straight forward or immensely complex. In our own review of developing data models, the one thing we can say for certain is healthcare is fluid.

At a macro level: Each time the FDA approves a new medication, or a state expands social benefits(Medicaid) or legislatively, laws like ARPA fundamentally change the APTC formulas, or health systems merge, insurers enter, or increase plan offerings in a county….recommendations can change. Each plan year as QHPs adjust benefits like Telemedicine, Drug Benefits, Network Type (PPO, HMO…), or insurer/health system contract expire recommendations change.

At a micro level: Life Happens…whether it is a baby, marriage, divorce, a big move, retiring early, getting a promotion, or jumping out of your comfort zone to start a business, your household size and/or income changes. Or a critical diagnosis, a whole new care team, or an external accident causes your medical needs to change.

With both micro and macro tensions, we want to reiterate the methodologies will either be relatively straightforward or immensely complex.

Straight forward algorithms will more commonly be presented by web brokers who wish to reduce their liability by avoiding any pointed recommendations that may not account for specific variability in the circumstances of the enrollee.

Systems more complex algorithmically will naturally have an internal guide for systems.

Here is our concern:
This precedent goes back quite a while. In finance, in 1933 after the great depression the Securities Act of 1933, commonly referred to as the Paper Act, was introduced. The Paper Act in its simplest form required any publicly traded investment to provide investors with all of the financial information they need to make an informed decision. Fast forward to 2022 and we are still getting 50-to-150-page prospectuses annually for every stock, mutual fund, ETF or the like, which we have in our 401(k), IRAs, or brokerage accounts. The people who generally read these documents are those people working in the industry making recommendations. In this case, the premise of a web-broker is to use a tool without an additional individual(broker/assister) to interpret for you.

We propose two options:

1. To have a DE/EDE contract with CMS and to have ANY recommendation component beyond filter and sort on the site the web broker agreement would require the methodology be securely shared with the agency to stress test for biases. The DE/EDE entity would retain the rights to all methodologies and CMS would be prohibited to use them for self-gain. This would protect intellectual property infringement and instill consumer confidence.
2. Instead of requiring entities to make available the methodology for the default display of QHPs, along with a plan recommendations consumers would receive a recommendation summary indicating their specific recommendation.

EXAMPLE

"Because you indicated you were pregnant, you need access to XYZ Hospital, and your income is $XX,XXX we have found the ABC Insurance plan will have the broadest network and the lowest copays for specialty care which may come in handy as you see specialists. All health plans are required to over essential health benefits…should you have a need for additional ultrasounds or glucose monitoring this plan will offer the most all in savings."

Additionally, as mentioned above, if the only people dedicating an afternoon….or in this instance longer…to interpret an algorithm is competitors, then this is an infringement on intellectual property as well as trade secrets. Brokers are the closest point of contact to the consumer. What is to stop a carrier from using web-broker methodologies to carve out an expense from their bottom line? Ultimately, brokers in the individual markets are advocates for their consumers. Unlike having employer-based insurance, consumers know, and often reach out to their broker for personal guidance. This poses an unnecessary risk to an industry which affected more than 50% of the enrollments done between the FFM and SBMs.

Agent liability for income projection

Under the section headed "I. PROVIDING CORRECT INFORMATION TO THE FFES" you reference 45 CFR § 155.220(j)(2) and the corresponding standards of conduct governing "agents, brokers, or web-brokers." These comments are in reference to the fourth proposal of 45 CFR § 155.220(j)(2)(ii)(D). The spirit of this proposal, from our point of view, is to shore up inconsistencies between the reported and actual income. This benefits consumers in three ways. 1. It requires agents and brokers to report the correct income at the direction of the consumer ensuring accurate figures. 2. It maintains program integrity by holding enrollers accountable for intentional misleading actions which put the financial needs of the agent ahead of the needs of the consumer. 3. It reduces the margin of error from reported to actual.

Comments:

1. Ethics
    a. It was indicated "the agency observed several instances of brokers providing inaccurate consumer household income projections on exchange applications to lower a consumers premium." Or worse, a broker batch enrolls individuals in $0 premium plans. Each year agents are required to do compliance training and sign multiple documents attesting we will not operate in this manner. Additionally, for each time we pull a healthcare.gov application(either with the client in person, or via a DE/EDE gateway) we must attest we have authorization by the client to access their account. In any case where you "observed several instances" then the current infrastructure would give you authority to penalize or hold the representative accountable for their actions.

2. Attestation
    a. In the event the client, or their representative, was to be required to attest to the accuracy of information. How would it look in practice? If it were a separate system, then the extra step would be a burden to enrollees and could cause a decrease in enrollments. If it were a checkbox within the application, then as stated above, if you are concerned about bad actors checking a box that said they had authority, when they did not, then they will check this box without thinking anything of it. For the rest of the 13 million applications, this adds steps other existing infrastructure can address.

3. Literacy – Agents, Brokers, Navigators, Assistors, CACs, and Marketplace
    a. The Individual Health Insurance market is the ONLY insurance market where intimate knowledge not only of drugs, providers, insurers(all the stuff related to insurance) is key, but a working knowledge of PERSONAL TAXATION is required. The number one complaint we hear from accountants is someone put in the wrong information and now they are stuck telling the consumer to prepare for a five-figure balance they owe the IRS. The proposed rule states "the agent, broker, or web broker may answer questions posed by the consumer or their authorized representative related to household income projections."

b. As recent as TODAY I had a marketplace representative tell the client, “If the child is under 21 and in your house…it does not matter…you have to claim them as a part of the household.” She called me in hysterics, and I had to pull LAWS to show this was not the case. In her case her grandchild was staying with her because their parents house the furnace went out. The kid went to private school and still had everything paid for by her parents. We have seen people get advice to count child support as income. We have seen all sorts of scenarios.

   There is an assumption brokers should be able to discuss income because: a W2 employee making 40k a year is not hard to put into the system. The challenge is we have four key archetypes and only one is that simple.

   In the US about 180 million people have access to MEC through an employer. Another 70 million are on Medicare. 30 million are Medicaid eligible. So that leaves a section remaining who does not have access to MEC. Typically, they fit into the following camps.

   1. Self Employed – Depending on if they are just getting started with their business, established, or mature really drives the recommendations. New startups tend to be cash poor as companies dump every dollar, they have back in to make the company go. A look at their Profit and Loss can show zero or negative income. In most states this makes them eligible for Medicaid. If they are established, we have to determine if they are a Sole Proprietor, LLC/Partnership, LLC/S Corp, an S Corp, or a C Corp. A few are pass through entities who have self-employed health insurance and self-employed taxes deductions(50%). Self employed individuals often struggle with whether to count what hits their bank account, or what is on paper. They also struggle to predict future sales. To a realtor this is a big difference between closing 5 and closing 50 homes. Right now, markets are hot, but if they cool down where will their income be? I have had businesses, when asked for their income, they told the marketplace $500,000. A deep dive into their documents revealed after business deductions their MAGI was $55,000. They were floored when they realized they would get $21,600 in APTCs. I have had people who have a large Self-Employed health insurance deduction not realizing their AGI was going up because the new, cheaper plan they want reduced their upcoming deduction. There are a lot of considerations for this market. Being there are 24 million people in this category we must take it seriously.

   2. Small Employers (<50 FTEs) – For small employers trying to balance employee benefits, they determine whether a group plan, an ICHRA, a QSEHRA, or no plan is the right move. Often the last option is the easier of the groups. When we deal with micro groups, they are often comprised of a few executive type people and many rank-and-file people. The executives go through a similar process as

the “Self Employed” group since they often have executive compensation agreements. The Rank and File who make $30k to $40k are prime candidates to benefit from the ACA. They fit the simplicity mold generally since they receive a W2 and live a straightforward life as far as income is concerned.

3. Early Retirees – This group of almost 65-year-olds are often looking for coverage for one of two reasons. 1. An older spouse retired and went on Medicare, and they need something until they get 65. 2. The couple was financially sound and able to retire early. For this population we routinely run into Data Matching Issues and have more help from other team members(their advisor) to identify what assets they intend to live on for the coming years. We do routinely remind them that “The year you turn 65, even though your birthday is in July, you have to keep your income steady through December.”

4. Transition – This last group is comprised of people who turn 26, or get laid off, or just moved to the area. They are what SEPs are made for. Each one could be as simple as a W2 or as complex as a Self-Employed person.

Fortunately, 11 years of experience in insurance, and 5 years as a licensed financial advisor helps our customers know the entire picture. Insurance agents cannot be expected to have an intimate understanding of taxation, nor should a consumer face a $21,600 discrepancy because they cannot get adequate advice.

Again, we routinely see “do not give tax advice”, but then we also contend with statements like this: “the agent, broker, or web broker may answer questions posed by the consumer or their authorized representative related to household income projections.”

4. Literacy – Consumers
    a. Ask a consumer what their income is, and they can give you any number of answers. Routinely they do not know the difference between the terms “gross” and “net.” Some think to use last year’s income, some assume taxable income, they just don’t know what is right. If it is truly the position of the agency(CMS) to help underserved populations then we need to give them a fighting chance. They need access to the right information, and the maze to calculate this number has several dead ends.

5. APTC Calculation
As a consumer, from November of year 1, to January of year 2 when coverage starts, to April of year 3 when taxes are reported there is a total of 16 months. Not only can a lot happen during this time, but there is a long time to discover what you thought you did right was very wrong. And now, you owe a large sum to the IRS. In lieu of legislation imparting the burden of income projections on the consumer or their broker, why not use systems which already exist?

a. In 2021, ARPA showed fundamental changes to the APTC calculations can be adjusted as is necessary to ensure populations are covered. The correlation between Household size, FPL and APTC affordability multiple was adjusted.

b. Additionally, there is a long-standing process known as IRMAA, in Medicare, which CMS uses to determine costs due by an individual based upon past income numbers. These same provisions allow consumers the flexibility to appeal IRMAA decisions should there be a change from the year used to determine the IRMAA to the present year.

c. Recommendations:
   1. Use the prior year SLSCP within the county to determine the benchmark rate for APTC. This will serve two purposes. It would allow insurers in their fall notices to consumers to accurately advise on what their renewal premium rate would be. They would have from October of the prior year when rates are declared up through the fall of the year, they would be distributing notices to calculate ACCURATE renewals. Additionally, this offsetting the benchmark by a year from the current lineup would not allow carriers to use a silver APTC strategy allowing them to push for the SLSCP slot and lowball their other offerings to gain market share. We have seen this when HMOs push into a market, pick a slim network and price their products lower. Consumers who stay put see a major hike and jump ship. With this program Insurers would also have a year to address their upcoming plan rates by considering the incoming SLCSP.

   2. Like IRMAA, use the income from the most recent return or the year prior to determine affordability. Then honor the APTC. Consumers would still be required to report to the IRS, but reconciliation would go down, and any risk of large amounts of money being owed would be greatly reduced. We have seen interagency progress in the past. Case in point, ICHRA, and QSEHRA legislation was drafted with parties from HHS, Treasury, EBSA, and DOL. We are confident if you get the right people in the room this can be done.

Agent/Broker/Web-broker input compliance

Related to broker conduct: We do agree brokers should be required to put in a **client's** email, phone number, and address. The client needs to be notified of the SEP in question. And it should be codified that Identity proofing should be related solely to the consumer in question.

Re-Enrollment Mapping Authority

Under this section you indicated a consideration during the autorenewal process, should a consumer be enrolled in a bronze plan in the prior year, but a Silver Plan is at or lower in cost to the prior year coverage is available, the FFM would potentially reroute them to the silver plan. We like the spirit of trying to improve the financial position of consumers. The questions we would pose are as follows:

1. We would request if the change were made, a metal change should remain within the same carrier. This is because consumers with underlying health conditions could face adverse consequences if they are changed to a plan which does not include their current doctors, or medications on their drug formulary are more expensive. In a case like the second scenario the system may notice a metal switch would be cheaper in the form of premium, but the added cost of medication increases is a net higher expense. Plans with the same carrier tend to have the same formulary in a given market.

2. From the consumers perspective, inaction(auto-reenrollment) ensures their existing coverage would continue at a reasonably similar makeup. They are anticipating at or lower costs to premium, copays, deductibles, and the like. If a metal shift to silver with the same carrier provides lower premiums, and better copays then we do see how the essence of this proposal would be welcomed and in the best interest of the consumers impacted.

User fee

The user fee mentions no change from PY2022 to PY2023 in the percentage being allocated from health insurance premiums. We recognize states that use the FFM are paying slightly higher than states who have their own SBM.

To reiterate our sentiment from the 2021-13993 CMS Comment Period,

"86 Fed. Reg. 35,173 (July 1, 2021) Since a large majority of plans are APTC eligible, the user fee seems to be a moot point. According to KFF[1] the outlay of APTC for 2020 was over $50 Billion dollars. So, the FFM paying APTCs and then recouping 2.25 or 2.75% of premiums just seems like taking money out of one pocket and putting it in the other. I think the larger question is how do we reduce plan premiums, thus reducing the APTC outlays?"

1| https://www.kff.org/health-reform/state-indicator/averagemonthly-advance-premium-tax-creditaptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

IN SUMMARY

All in all, we value the efforts HHS, CMS, and CCIIO go through year in and year out to both preserve the integrity of the markets and push to improve access to healthcare for the community as a whole. We also want to thank you for taking the time to read our feedback.

To quote Adam Grant, Professor at the Wharton School of the University of Pennsylvania, ”those who are the closest to a problem tend to be the closest to the solutions.”

We value these comment periods as an opportunity to give a boots on the ground perspective of the impacts we see day in and day out with the actual consumers these proposals are going to affect. This comment period is meant to solicit feedback, and we appreciate the opportunity to give you experiences to frame future policy decisions. Americans deserve access to quality **and** affordable insurance. Much of the healthcare industry discusses diagnostic outcomes, health treatment literacy and adequate protection for consumers. We also, collectively, need to ensure health treatment does not cause financial outcomes which are detrimental to individuals. Additionally, we need proper coverage and policy to reduce discrimination, and help disadvantaged subpopulations who have been adversely impacted by inequality in the past.

Again, thank you,

Joshua Brooker, REBC®, ASF, ABHP, ESP
Principal