SnapHealth

January 27, 2023

Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-9899-P | Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024

Dear Administrator Brooks-LaSure, Secretary Becerra, Deputy Director Dr. Montz, and the entire staff involved with research and development of this proposal,

We are writing in response to the notice of payment parameters (NBPP 2024) proposed rule that was published in the Federal Register on December 21st, 2022. We appreciate the opportunity to provide comments on this important proposed rule.
For context, and full disclosure, our organizations are:

PA Health Advocates, a healthcare brokerage focused on helping individuals navigate the health insurance market. Our expertise in the individual health market allows us to work directly with customers across 13 total states spanning both FFM and SBM Markets.

SnapHealth, our Benefit LLC is digitizing many of PA Health Advocates processes with an expressed mission of improving patient health. With a digital system, we leverage Interoperability, Patient Access API, FHIR/ONC Protocols, and No Surprises Act Transparency regulations to bring robust tools direct to consumers to not only acquire quality health insurance, but be provided tools to actually interact with the health markets efficiently.

Helping Health, our 501(c)(3) nonprofit operates as a community-based organization serving the Pennsylvania Market to assist the market in applying for Medicaid and Financial Assistance applications through hospital Charity Care programs.

We have three core missions within the financial side of healthcare: 1) working one-on-one with consumers to help them efficiently navigate the system, 2) working with trade groups and government workgroups at HAFA, NABIP, CMS/CCIIO, and Pennie to indirectly help the broader market and advise on consumer needs, and 3) working with Congress and government agencies to report inadequacies, inequities, and consumer catastrophic claims that need policy changes to stop dangerous recurring events.

Office of: Joshua Brooker
jbrooker@mysnaphealth.com
717.400.1244
342 N Queen St, Rear, Lancaster, PA 17603

We have carefully reviewed the proposed rule and have comments to offer regarding the following topics.

- No Binder Payment – Zero Premium Remapping
- Section 153(2)(A) Market Adjustment
- Section 155.106 State Waiver Timelines
- Section 155.210(d)(8) Navigator Marketing
- Section 155.305 Failure to Reconcile Extension
- Agent/Broker Consent
- Section 155.315/155.320 Income Attestations
- Section 155.335 Annual Mapping
- Section 155.420 Mid Month SEP
- Section 155.420(d) Provider Network Change SEP

No Binder Payment – Zero Premium Remapping

The proposed rule asks for comment on move consumers to a zero-premium plan in the event the consumer enrolls in a qualified health plan during open enrollment, but fails to pay their premium by the 12/31 deadline.

We would like to express our concerns about the proposal to automatically move consumers who do not pay their binder payment by the deadline to a zero-premium plan. While we recognize that the zero premium plan may be more affordable for some consumers and provide a safety net for those at risk of losing coverage, there are also several potential drawbacks to this proposal.

One concern is that the automatic switch to a zero premium plan could be confusing and disruptive for consumers, who may not have been expecting to be enrolled in a different plan. The new plan may not offer the same coverage or provider network as the original plan, which could cause difficulties for consumers who are already receiving care or have established relationships with certain providers.

Additionally, consumers may not have a choice in whether to switch to the zero-premium plan, even if they prefer their original plan or are able to pay their binder payment at a later date. This could limit their ability to make informed decisions about their healthcare coverage.

Finally, in previous years, we have noted that the accuracy and timeliness of outstanding premiums have not always been accurate. Consumers may make a binder payment, but if the data isn't shared from the carrier to the marketplace either accurately, or by the deadline, the consumer may be mapped to another plan causing further confusion.

Overall, while we recognize the potential benefits of the zero-premium plan, we believe that it is important to carefully consider the potential drawbacks and ensure that consumers have the ability to make informed decisions about their healthcare coverage.

Office of: Joshua Brooker 717.400.1244
jbrooker@mysnaphealth.com 342 N Queen St, Rear, Lancaster, PA 17603

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Section 153(2)(A) Market Adjustment

The proposed rule asks for comments on determining the market basket update as outlined in section 153(2)(A) of the Affordable Care Act. As you are aware, the COVID-19 pandemic has had a significant impact on healthcare costs, with spending increasing by over 10% in 2020 according to a recent study published in Health Affairs (https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.01397).

Considering this, we believe it is important to consider options that take into account the unusual circumstances of 2020, consider smoothing over both this coming plan year and future years, and ensure that payment rates accurately reflect the current market conditions for healthcare services.

Based on your recommended options, and the Health Affairs study, we believe it will be prudent to use data from 2017-2020 in order to spread out the assumption of the increase in costs over a longer time period. This would also hold true for the next NBPP that will account for the 10% spike in 2020, but also use the lower-than-average spending reflected in 2021 numbers. It may be prudent to adjust 2017 numbers due to inflation to reflect spending more accurately.

We appreciate the difficult task of determining payment rates in the face of unprecedented challenges, and we hope that these suggestions may be helpful in your considerations.

Section 155.106 State Waiver Timelines

The proposed rule addresses a concern that we share about the current timeline for states to transition to a State Based marketplace. As outlined in section 155.106, states are required to have 3-14 months (depending on type of waiver) from the time CMS greenlights their transition to when their system can be live for open enrollment. We believe that this timeline is insufficient and that CMS should have more time to properly prepare for this transition. We have now participated in the PA, NJ, MD, and NM (and VA currently) markets as they transitioned away from FFM, and states need more ramp up time to iron out kinks.

There are several reasons why we believe that CMS and states should have more time to transition to their SBM marketplace. First and foremost, this will help individual consumers to have more time to prepare for this transition. Many individuals rely on the ACA marketplace for their healthcare coverage, and a rushed transition could lead to confusion and uncertainty for these individuals. By giving states more time to transition to the SBM marketplace, individuals will have the opportunity to better understand what the shift means. An example of prior transitions was in Pennsylvania (our resident state). We routinely met consumers who believed that **the plans** were different because they couldn't get healthcare.gov coverage anymore.

Additionally, more time for the transition will benefit insurers and enrollers as well. Insurers and enrollers need time to prepare for the transition to the state's marketplace, including updating their systems and processes to comply with the new requirements. A core tenant of the SBM waiver is for states to show how their unique approach to the market would save federal funds. This "unique" autonomy adds additional considerations for insurers and enrollers as state level rule making varies from FFM rules. A rushed transition could lead to delays and difficulties for these stakeholders, which could ultimately impact the quality of care and coverage that individuals receive. By giving states more time to transition

Office of: Joshua Brooker 717.400.1244
jbrooker@mysnaphealth.com 342 N Queen St, Rear, Lancaster, PA 17603

to the SBM marketplace, insurers and enrollers will have the opportunity to properly prepare and ensure that they are able to provide high-quality care and coverage to individuals.

In conclusion, we strongly believe that CMS and states should take more time to transition to SBM marketplaces. This will help individuals, insurers, and enrollers to have more time to prepare for this transition and ensure that the marketplace is able to function effectively and efficiently. We encourage CMS to consider extending the timeline for the transition to the State marketplaces to allow for a smoother and more successful transition.

Section 155.210(d)(8) Navigator Marketing

Next, we have concerns about the potential impact of removing subsection (d)(8) of 45 CFR § 155.210 from the ACA. This provision currently prohibits navigators from conducting door-to-door enrollment activities. We believe that removing this provision could have several potential negative consequences.

Allowing navigators to conduct door-to-door enrollment activities could raise concerns about privacy and unwanted solicitations, as some consumers may not feel comfortable with uninvited visits from enrollment assistance staff. It could also lead to confusion or misunderstandings about the nature of the assistance being offered, as some consumers may not be aware that navigators are trained and certified by the Department of Health and Human Services (HHS) to provide assistance. Allowing navigators to conduct door-to-door enrollment activities could raise questions about their impartiality.

Similar to the Medicare rules regarding Education and Marketing events, CMS has argued that educating the public in conjunction with marketing to the public creates confusion. Consumers not knowing the context of these door-to-door activities may further dilute their impact.

Lastly, we feel very strongly that both Navigators and Brokers have a separate and distinct role within the health insurance market for individuals. Consumers above 150% of the Federal Poverty Limits, especially those with multiple sources of income, need more support when it comes to informed projection of income for the subsequent year. By allowing door-to-door enrollment activities by Navigators, but not FFM Registered Brokers, you risk EITHER a navigator outside of their depth and inaccurately estimating income because they are in the home and trained to enroll on the spot. Alternatively, if this is allowed for Navigators, but not brokers, you are keeping a better qualified resource, the broker, from assisting a consumer due to a different standard where Agents and Brokers are not given the same authority to process door-to-door enrollments.

We urge you to consider these potential problems, to consider aligning Navigator and FFM Registered Broker governance and the importance of maintaining the integrity and lastly, considering the credibility of the navigator program before making any changes to this provision. Thank you for your attention to this matter.

Office of: Joshua Brooker 717.400.1244
jbrooker@mysnaphealth.com 342 N Queen St, Rear, Lancaster, PA 17603

Section 155.305 Failure to Reconcile Extension

The proposed rule makes mention of potential change to Section 155.305 of the ACA, which currently requires exchanges to remove premium tax credits (PTCs) if the IRS determines that an individual did not reconcile their PTCs for the previous year.

One potential pro of changing the rule to a two-year period is that it could give individuals more time to reconcile their PTCs and avoid having to pay back any excess credits. This could be particularly beneficial for individuals who have complex financial situations or who have difficulty navigating the process of reconciling their PTCs. In addition, such a change could help to prevent situations where individuals have filed an extension with the IRS in April and have not yet filed their return by the time the IRS reviews PTCs, resulting in the exchange removing PTCs even though the individual's tax situation may ultimately be found to be in compliance.

However, we also recognize that there are potential cons to changing the rule to a two-year period. One concern is that a two-year reconciliation period could lead to more instances of fraud or abuse, as individuals may be able to receive excess credits for a longer period of time before they are detected and required to pay them back.

One further consideration is that for individuals who exceed 400% of the federal poverty limit, the amount of PTCs they could be subject to pay back could be much higher than for lower income households, and a two-year reconciliation period could result in a higher repayment effect for these individuals.

We believe that the decision to change the rule from a one-year to a two-year period should be carefully evaluated, taking into account the balance of the potential pros and cons as well as the specific circumstances and needs of the individuals and small businesses participating in the exchanges.

Agent/Broker Documented Consent

The proposed rule seeks feedback on a proposal that agent, brokers, or web-brokers must document a consumers consent to help them prior to assisting the consumer

In reviewing this proposal, we first recognize that ALL enrollers (Agents/Brokers/Web-Brokers/FFM Call Center Representatives/Navigators/Assistors/CACs) DO NOT have independent discretionary authority (without some form of consent by consumer) to:

1. View an individuals PII/PHI

2. Pick which plan the consumer enrolls in

3. Effectuate coverage without the expressed consent of a consumer.

This is both indoctrinated in law, but also good ethical practice. No one should be accessing your or my information without consent. This should be a simple practice.

Currently, in order for an enroller to access any information about a consumer through the FFM, they must either use a DE or EDE platform, or assist their client directly from the client side healthcare.gov portal. It is illegal to create, maintain, or use healthcare.gov consumer credentials. Because of this, we

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jbrooker@mysnaphealth.com 342 N Queen St, Rear, Lancaster, PA 17603

see that the effort in this proposal is to document consumer consent DE and EDE access and interaction with consumer data.

Within the DE and EDE frameworks, any time an enroller looks to access and subsequently pull a record into their account, the enroller is required to attest "I've received permission from this consumer to work on their behalf." Additionally, within the Agent Broker General Agreement that must be signed each year, it states: "ABE may only conduct person searches for Consumers who have given the ABE consent to access and use their personally identifiable information for purposes of assisting the Consumer in applying for and enrolling in a QHP or other Insurance Affordability Program through an FFE or SBE-FP." This is CURRENTLY in place.

Misrepresenting this attestation constitutes fraud. Under 45 CFR § 155.220(f)-(m) outline the recourse that HHS has at their disposal to deter bad actors from misrepresenting this consent.

Fundamentally, we see two issues when it pertains to consent. 1. Misrepresentation and Enforcement. According to the AB Registration Completion List, for plan year 2023 there are over 74,000 brokers supporting individuals. Additionally, since 2016 there are around less than 700 that are terminated from the FFM. When looking at the data, it can be inferred that either 99% of brokers are in compliance, and/or enforcement is down. When looking at the AB suspension list, it does look as if more bad actors are being removed than years past. That said, what we hear from other Agents/Brokers who have reported bad eggs, they note many cases where no action is taken. Additionally, within CCIIO we have been told that mechanisms used to track complaints alert the teams of suspicious activity that results in "reminding the AB that they can't just access data without permission." Before any consequences are passed on.

Our concern is that adding a requirement that a broker get a form signed consent is adding additional steps to a consumers enrollment process that is already addressed by the broker DE/EDE attestation and current policy. Bad actors will continue to skirt regulations and need to be removed through enforcement. Good actors, and consumers shouldn't be required to hold account.

Consumer Review Attestations

The proposed rule suggests that a consumer attest that they have read and reviewed all information before the enroller has submitted their plan. We see concerns when we parallel the role of an enroller to other professional industries. When you need healthcare, or legal help, or tax and accounting work, you are often leaning on the guidance of others to help you from the moment you make your problem known, to the solution. When it comes to enrollers, regardless of ABs, or Navigators, the questions are usually asked of the consumer, and inputted by the enroller.

That said, when a person is not face to face, they are not reviewing each and every input as they are typed in. Because of this, we see a problem with consumers being required to attest to reviewing an application. Many consumers have never logged into their account, have relied on the enroller and the DE/EDE system, and have had their plan selection finalized by the enroller, and paid the premiums they have to the carrier.

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jbrooker@mysnaphealth.com 342 N Queen St, Rear, Lancaster, PA 17603

We see a barrier to enrollment if enroller has to read an attestation to a consumer that they are having a call with and either the call needs to stop and the individual must open the app on their end and complete it, or the client gives a verbal authorization and reviews the application after the fact. I think the various ways that consumers seek help and buy insurance should be considered before implementing this type of attestation.

Section 155.315/155.320 Income Attestations

The proposed rule solicits comments on the use of consumer attestation in the ACA Health Insurance Marketplace to address income inconsistencies. Section 155.315 and 155.320 of the Affordable Care Act (ACA) relate to income inconsistencies when an individual is applying for coverage through the exchange. These provisions require that the exchange verify an individual's income in order to determine their eligibility for premium tax credits and other cost-sharing reductions.

One option for addressing income inconsistencies is for the exchange to accept an attestation from the consumer, in which they affirm that their projected income for the coming year will be different from their prior year income. While this approach has the potential to be more streamlined and efficient, and may be more convenient for the consumer, there is a risk that the consumer's attestation may not accurately reflect their actual income for the coming year. Additionally, if the exchange relies solely on an attestation and does not verify the consumer's projected income, it may be more vulnerable to fraud or abuse.

In Pennsylvania, the current process for addressing income inconsistencies involves requiring the consumer to submit their taxes, two additional documents, and undergo an outbound call from the state before an attestation can be accepted. While this process may be more thorough in terms of verifying income, it may also be more burdensome for consumers compared to simply accepting an attestation without these additional requirements. There are a few ways in which accepting an attestation may reduce the burden on consumers compared to the current process in Pennsylvania: it may reduce the amount of paperwork that consumers need to complete, reduce the risk of transmitted documents being at risk of cyber security events, allow for a quicker resolution of income inconsistencies, and be more convenient for consumers.

Overall, it may be necessary to balance the convenience and efficiency of accepting an attestation with the need to ensure accuracy and prevent fraud. In states, like Maryland, we have seen an attestation with a space to explain why prior electronic data of income, and prior tax documents may not reflect upcoming income. This would strike a balance between the risk and reward as consumers will not only attest to their projected MAGI, but offer an explanation as to WHY it is changing. Events like having a child, retirement, self employed income swings, and many other life events routinely cause MAGI changes that can be explained within the attestation.

Section 155.335 Annual Mapping

Section 155.335 of the Affordable Care Act (ACA) relates to the annual process of redetermination, which involves reviewing an individual's eligibility for premium tax credits and cost-sharing reductions

Office of: Joshua Brooker 717.400.1244
jbrooker@mysnaphealth.com 342 N Queen St, Rear, Lancaster, PA 17603

(CSR) and determining the appropriate level of assistance. This provision currently requires the exchange to map individuals to different plans based on their income and household size, as well as other factors such as their tobacco use and any special enrollment circumstances.

If CMS were to change this provision to include network IDs, net premium, maximum out-of-pocket (MOOP), and CSR in the mapping process, it could have some potential pros and cons:

Pros:

- Adding these factors to the mapping process could provide a more comprehensive and accurate assessment of an individual's needs and preferences. Network IDs, for example, could be helpful in determining whether a particular plan is a good fit for an individual based on their access to preferred providers.
- Including net premium and MOOP in the mapping process could help ensure that individuals are enrolled in a plan that is affordable and meets their financial needs.
- Incorporating CSR in the mapping process could help ensure that individuals receive the appropriate level of assistance based on their income and other factors.

Cons:

- Adding more factors to the mapping process could make it more complex and time-consuming for the exchange to develop multiple use cases to find the appropriate plan for an individual. This could lead to delays in the redetermination process.
- It could also be more challenging for individuals to understand and navigate the mapping process if there are more factors to consider and it isn't clear from the prior plan to the new plan, which variables are the most prudent.
- There may be additional administrative and logistical challenges involved in implementing these changes, which could impact the overall efficiency and effectiveness of the redetermination process.

Additional consideration of Gold plans vs CSR73:

As for the idea of considering a map to a gold plan when someone has CSR73 if the premium is cheaper, this could potentially be a good idea in some cases. Gold plans generally have higher premiums than other metal levels, but they also typically offer lower out-of-pocket costs and more comprehensive coverage. If the premium for a gold plan is cheaper than the premium for a plan with CSR73, it may be worth considering for an individual who is eligible for CSR73. However, it's important to keep in mind that there are other factors that may also be relevant, such as the individual's access to preferred providers, their financial needs and preferences, and their overall health status. It may be helpful for the individual to carefully compare the costs and benefits of different plan options to determine which one is the best fit for their needs.

Section 155.420 Mid Month SEP

The proposed rule seeks feedback on changes to Section 155.420 of the Affordable Care Act (ACA). This section relates to special enrollment periods (SEPs), which allow individuals and families to enroll in

a health insurance plan outside of the annual open enrollment period. According to this provision, the start date for an SEP is typically the month following the event or enrollment, whichever is later. This means that if an individual experiences a qualifying event (such as a change in employment status or a move to a new area) that allows them to enroll in a new plan through an SEP, their coverage will typically begin the month after the event or their enrollment date, whichever is later.

Allowing the start date for an SEP to be whichever is earlier (rather than whichever is later) could potentially have some pros and cons:

Pros:

- Allowing consumers to enroll on the first of the month that has a loss of coverage mid month could allow them to get coverage sooner in some cases. For example, if an individual experiences a qualifying event in the middle of the month and enrolls in a new plan through an SEP, their coverage would typically start the following month under the current rules. Removing this requirement could allow their coverage to start earlier, potentially reducing any gap in coverage.
- This change could also help ensure that individuals have access to timely and continuous coverage, which is important for their overall health and well-being.

Cons:

- Making this change, however, could result in individuals enrolling in a new plan earlier than they intended or were aware of. For example, if an individual experiences a qualifying event and enrolls in a new plan through an SEP, but does not realize that their coverage will start immediately, they may end up paying premiums for coverage they do not need.
- This change could also potentially result in confusion or misunderstandings about when coverage will begin, which could lead to issues with billing and payment.
- Allowing the start date for an SEP to be whichever is earlier could also have financial implications for the exchange and insurers, as it could potentially result in a change in the length of coverage periods and the amount of premiums collected.

Overall, it's important to carefully consider the potential pros and cons of allowing the start date for an SEP to be whichever is earlier before making any changes to this provision. It may be helpful to consult with stakeholders (such as insurers, consumers, and healthcare providers) and conduct an analysis of the potential impacts of this change before deciding whether to move forward.

Section 155.420(d) SEP for Network Changes

The Centers for Medicare and Medicaid Services (CMS) is proposing a change to section 155.420(d) of the Affordable Care Act (ACA) that would create a special enrollment period (SEP) for individuals who are enrolled in a qualified health plan (QHP) and whose provider is no longer in network during the plan year.

This change could potentially have some pros and cons:

Pros:

- Creating an SEP in this situation could allow individuals to enroll in a new QHP that includes their provider in its network, which could be important for maintaining access to care. This could be particularly beneficial for individuals who have ongoing medical conditions or needs that require ongoing treatment from a specific provider.
- An SEP could provide a more flexible and responsive solution to changes in provider networks, as it allows individuals to enroll in a new plan if their provider is no longer in network.

Cons:

- Creating an SEP could potentially lead to disruptions in coverage and additional administrative burden for individuals, as they would need to enroll in a new plan and potentially switch to a new provider. This could also be disruptive for providers, as they may need to transfer medical records and establish a new care relationship with the individual.
- An SEP could also have financial implications for the exchange and insurers, as it could potentially result in a change in the length of coverage periods and the amount of premiums collected.

One alternative approach to addressing provider network changes could be to require the provider to accept in-network rates through the end of the plan year. This approach could have some pros and cons as well:

Pros:

- Requiring the provider to accept in-network rates through the end of the plan year could help ensure that individuals have continuous access to care without the need to switch providers or enroll in a new plan.
- This approach could also reduce administrative burden for individuals and providers, as it would not involve enrolling in a new plan or transferring medical records.

Cons:

- Requiring the provider to accept in-network rates may not be feasible in all cases, depending on the terms of the provider's contract with the insurer.
- This approach could potentially result in financial implications for the provider, as they may not receive their usual reimbursement rate for the services they provide.
- It could also have financial implications for the insurer, as they may need to pay higher rates to the provider in order to ensure that individuals have access to care.

Another Alternative Approach is requiring provider and insurer contracts to run on a calendar year basis and finalized before the plan year open enrollment period. This, also, could potentially have some pros and cons:

Pros:

- Having provider and insurer contracts run on a calendar year basis could potentially provide more stability and predictability for individuals, as their coverage would be aligned with the

Office of: Joshua Brooker 717.400.1244
jbrooker@mysnaphealth.com 342 N Queen St, Rear, Lancaster, PA 17603

calendar year. This could make it easier for individuals to understand and plan for their healthcare needs and expenses.

- A calendar year basis could also provide more clarity and consistency for providers, as their contracts would be aligned with the same timeframe. This could potentially reduce administrative burden and make it easier for some providers to plan for their practice.
- Aligning provider and insurer contracts with the calendar year could also potentially make it easier to track and report on healthcare utilization and costs, as there would be a clear and consistent timeframe for these metrics.

Cons:

- Requiring provider and insurer contracts to run on a calendar year basis could potentially result in disruptions or gaps in coverage for individuals if they experience a qualifying event that would normally trigger an SEP. For example, if an individual experiences a change in employment status or a move to a new area during the middle of the year, they may not be able to enroll in a new plan with their care team until the following year.
- This approach could also potentially create financial challenges for providers, as their contracts would be limited to a calendar year timeframe. This could make it difficult for some providers to plan for their practice and manage their financial resources.
- It could also have financial implications for insurers, as they may need to adjust their rates and premiums to align with a calendar year basis.

Overall, it's important to carefully consider the potential pros and cons of requiring provider and insurer contracts to run on a calendar year basis before making any changes. It may be helpful to consult with stakeholders (such as insurers, consumers, and healthcare providers) and conduct an analysis of the potential impacts of this change before deciding whether to move forward.

We appreciate the opportunity to weigh in on these important topics. If you have any questions, please feel free to contact me at jbrooker@pahealthadvocates.com or 717-400-1244.

Sincerely,

Joshua Brooker, REBC®, ABHP, ASFC

CVO & Principal | Advocate for a Better US Health System By Working With Clients, Government, Industry Groups, and Press