



March 2, 2020

The Honorable Seema Verma  
Administrator, Centers for Medicare and Medicaid Services  
200 Independence Ave, SW  
Washington, DC 20201

**RE: 2021 Notice of Benefits and Payment Parameters - CMS-9916-P**

*Submitted Electronically via [www.regulations.gov](http://www.regulations.gov)*

Dear Ms. Verma:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. We are pleased to have the opportunity to provide comments in response to the proposed rule titled "Patient Protection and Affordable Care Act: Notice of Benefit and Payment Parameters for 2021" and referenced as CMS-9916-P.

The members of NAHU work daily to help millions of individuals and employers purchase, administer, and utilize health insurance coverage. Since the passage of the Patient Protection and Affordable Care Act (ACA), our members have worked directly and tirelessly with millions of individuals and employers of all sizes to help them obtain new coverage and comply with new requirements. Our work includes helping to place coverage through both the individual and Small Business Health Options Program (SHOP) marketplaces. Ensuring market stability and competition, as well as improving health coverage affordability, are among our association's top goals. Our comments are organized by section, and they reflect the views of experts who fully understand the needs and interests of today's individual and group health insurance consumers.

**Timing of the Final Rule**

NAHU appreciates the willingness of the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) to consider comments from all stakeholders on this critical regulation, which covers such a wide array of health policy issues. While we certainly hope you give adequate weight and attention to all viewpoints, we urge you to act with expediency when finalizing this regulation. Across all commercial health insurance market segments, plan design, and other administrative decisions for the 2021 benefit year will be affected by the content of the final rule. The release date of this proposed rule is the latest ever. So we are concerned that unless you promulgate a final option quickly, coverage options for all consumers in 2021 will be limited, and there will not be enough time to implement any new requirements.

**Requirements for the Group Health Insurance Market: Excepted Benefit HRAs Offered by Non-Governmental Plan Sponsors - §146.145**

The members of NAHU support the proposed requirement that all sponsors of excepted benefit Health Reimbursement Arrangements (excepted benefit HRAs) annually provide a notice to participants and beneficiaries about the various features of the excepted benefit HRA. This notice must include eligibility requirements, annual or



lifetime caps, and a summary of available benefits. The proposed rule compares the new notice to the summary plan description (SPD) requirements for employer-sponsored health and welfare plans covered by the Employee Retirement Income Security Act of 1974 (ERISA). Accordingly, the notification timeframe proposed in the rule for sponsored of excepted benefit HRAs is similar to the ERISA SPD requirements specified in 29 CFR 2520.102-3(j)(2) and (3).

According to the proposed rule, excepted benefit HRA notices would be due no later than 90 days after the employee became a participant in the excepted benefit HRA and annually after that. New ERISA health and welfare plan participants must be given a copy within 90 days of the start of coverage. Also, all plan participants must get a fresh copy every time the SPD is modified or updated, and once every five years if the plan is modified or ten if it stays the same. The proposed rule mirrors the ERISA disclosure rules by specifying the notice must be provided in a manner reasonably calculated to ensure actual receipt by participants eligible for the excepted benefit HRA.

NAHU members anticipate that most employers that elect to offer excepted benefit HRAs will not develop their notices but instead contract out compliance to a third party. In all likelihood, this third party will be the same entity that prepares the employer's other ERISA plan documents and disclosures. Hence, NAHU appreciates the proposed rule's attempt to conform with ERISA.

One of the questions in the proposed rule is if sponsors of non-federal governmental excepted benefit HRAs should be required to provide the notice annually after the initial notification. Alternatively, after delivering the initial disclosure, should a plan sponsor only be required to give a new notice if the terms of the excepted benefit HRA change? If so, the proposed rule asks for comments about what type or magnitude of change should trigger a subsequent notice. NAHU believes that CMS should consider using the ERISA material modification disclosure standards fully in these scenarios. In addition to the SPD distribution requirements we have already noted, for health and welfare plans, ERISA requires the plan participant to be notified of a material reduction in covered services or benefits at least 60 days before a change. This notice came come via a new summary of benefits and coverage or separate notification of the change. Also, plan participants must get an overview of any material modification to the plan within 210 days of the close of the plan year during which the modification or change was adopted.

The exception is that any material reduction in covered services or benefits needs to be added to the SPD no later than 60 days after the date of adoption of the modification or change. Material modifications, according to ERISA, include:

- any coverage modification that alone or combined with other changes made at the same time would be considered by "an average participant" to be "an important change in covered benefits or other terms of coverage under the plan or policy."
- an enhancement of covered benefits, services, or other more general plan or policy terms such as coverage of previously excluded benefits or reduced cost-sharing.
- a "material reduction in covered services or benefits," including changes or modifications that reduce or eliminate benefits and increases in cost-sharing.



The proposed rule does not provide for any type of template for the proposed notice, and there is no template for SPDs required by ERISA. The only specification is that it be written in a manner calculated to be understood by the average plan participant, which is the same standard used for the SPD. It is the observation of NAHU members that the lack of official templates, compliance resources, and education about SPD requirements hurts both employees and business owners. Participants suffer because the SPD materials that should provide them with information and protections are often confusing, incomplete, duplicative, or not available. Accordingly, NAHU urges different action from CMS when it comes to any final excepted benefit HRA requirements. Given that the Department of Labor's Employee Benefits Security Administration is actively considering changes to the ERISA disclosure rules and safe harbors, we ask that CMS make every effort to keep final requirements consistent with any updated ERISA disclosure guidance.

### **Employer-Sponsored Plan Verification**

The ACA established that people who have enrolled in any employer-sponsored health coverage or who are eligible for employer-sponsored health coverage that is affordable and provides minimum value are ineligible to receive federal tax subsidies for health insurance coverage offered through the health insurance exchanges. HHS originally planned to take an active role in verifying employer-coverage offers and enrollment as part of the subsidy-eligibility process. However, since 2014, HHS has been using a limited verification process, relying on information provided by the subsidy applicant, electronic verification data, and information from a random sampling of employers.

In the proposed rule, CMS indicates that it is considering eliminating the random employer sampling process, as it yields low participation and usable data from employers. Further, for the 2020 and 2021 plan years, CMS proposes to take no enforcement action against exchanges that fail to perform random sampling. However, the proposed rule also indicates that CMS is studying why people with job-based coverage might choose to enroll in a QHP over their employer's coverage. The results of this study are expected in the fall of 2020.

As we have commented many times previously, NAHU remains very concerned about the workability and effectiveness of the employer coverage verification, notice, and appeals processes as they currently stand with health insurance exchanges. NAHU believes that adequate exchange-based verification of qualified offers of employer-sponsored coverage would prevent many individuals from receiving subsidies inappropriately. It would also reduce the IRC §4980H employer shared responsibility penalty enforcement burden for both the IRS and employers nationally. Since our membership works directly with both employers that offer people qualified affordable and minimum value coverage and individual exchange consumers, NAHU members have a great deal of insight as to why employees with qualified offered of employer-sponsored coverage might decline such coverage in favor of exchange-based offerings. We would be happy to provide information and support to your efforts to study this issue in the year ahead, and we encourage you to contact us for this purpose.

### **Eligibility Redetermination during the Plan Year - §155.330**

If an exchange consumer is also enrolled in Medicaid or Children's Health Insurance Program (CHIP) coverage, CMS does not automatically terminate either type coverage. The reasoning behind this decision is the high number of people who switch between exchange-based coverage, and these two programs mid-year due to income eligibility variations. However, the new rule proposes a change of this policy for dually enrolled individuals who voluntarily terminate qualified health plan (QHP) coverage through a federally facilitated exchange and then do not



contest the termination of coverage within 30 days. In these cases, CMS will no longer redetermine their eligibility for premium tax credits or cost-sharing reductions during the termination process. NAHU supports this change for efficiency purposes.

### **Effective Date for Termination via Death PDM - §155.330**

The proposed rule would allow for the retroactive termination of QHP coverage back to the date of death for deceased individuals who do not contest the termination of coverage within 30 days. NAHU members support this change, as it would benefit the family of deceased beneficiaries. However, it also allows for a means of protection and continued coverage should anyone be deemed dead by mistake.

### **Auto Reenrollment - §155.335**

The proposed rule would make a significant change to the current policy concerning coverage auto re-enrollment and tax-credit determinations for the lowest-income consumers and solicits comments about this process. Beginning with the 2021 plan year, CMS proposes to continue to auto-enroll people who have previously qualified for an advance premium tax credit that allowed them to purchase a policy with no premium. However, when completing the auto-enrollment, CMS will discontinue tax credit eligibility pending determination. That means that very low-income exchange coverage beneficiaries would be enrolled in coverage for the new year but would have to pay substantial premiums for such coverage until they return to the exchange for assistance and a tax-credit reevaluation.

NAHU has long questioned the appropriateness of CMS's current practice of automatically reassigning people into new binding insurance contracts, including with new carriers or coverage terms, mainly when this can involve high cost and tax consequences for the enrollee. If an individual's current coverage option is no longer available through the marketplace, then we believe that CMS should make direct contact with the consumer and obtain consent before passively placing the individual in a new health insurance coverage option. However, we also have concerns with the changes in the proposed rule, which would not change the existing auto-enrollment and redetermination policies for low-income people but would simply remove their tax-credit-eligibility status.

Given that the new policy would only apply to specific very-low-income individuals, our members believe that it will generate a great deal of consumer confusion. Further, when newly confronted with premium bills to pay, low-income consumers could elect to drop coverage or not pay premiums rather than return to the exchange for a new income eligibility verification and premium adjustment. While the proposed rule pledges additional consumer outreach and assistance to combat this problem, NAHU members are not convinced further education will be sufficient to prevent enrollment confusion and disruption amongst this vulnerable population. NAHU understands the concerns that prompted CMS to consider this change. However, instead of adopting for the 2021 plan year, we urge you to conduct a study of the entire auto-re-enrollment and income-eligibility determination process for all populations. NAHU members would be happy to participate and provide input if you undertake this endeavor.

### **Special Enrollment Periods – §155.420**

The proposed rule would make multiple changes to the existing requirements related to special enrollment periods (SEPs). The first would be to allow individuals who experience a mid-year increase in income that makes them ineligible for cost-sharing reductions to switch to a plan in a different metal tier. Another would be to allow all people who become eligible for a SEP to join an exchange-based QHP mid-year if other members of their family,



such as dependent children, are already enrolled in that specific plan option. This provision would apply even if the business rules of the QHP typically would not allow that change. Off-exchange plans would not need to comply with this requirement, but they could if they wish. The proposed rule also establishes that moving forward with the 2021 plan year, all SEP prospective coverage enrollment dates will be the first of the month following enrollment in all cases, and binder payment rules will be adjusted accordingly. NAHU members support all three of these changes. Agents and brokers often encounter people who would be positively affected by each of these proposals, and we appreciate how your agency is being responsive to broker-identified SEP concerns.

Another change offered in the proposed rule addresses retroactive SEP effective dates in the case of delayed enrollment due to the length of the SEP verification process conducted by the exchange. The proposed rule would repeal the existing policy that allows consumers to choose between paying the premiums for all of the months that have passed due to the delay, or just pay one month's premium and receive prospective coverage. CMS indicates that the reason for this proposed change is that, over the past three years of conducting SEP verification, the agency has improved its processes so that there are rarely ever related enrollment delays. NAHU members can support this change; however, we ask that you continue to monitor SEP verification speed and return to the earlier process should any delays in verification resume. Otherwise, we have concerns about potential coverage loss, because few enrollees with SEP rights are capable of paying for multiple months of back premiums simultaneously.

Finally, the proposed rule would amend §155.420 to create SEP rights for individuals who have access to a non-calendar-year Qualified Small Employer Health Reimbursement Arrangement (QSEHRA). NAHU supports this proposal, as it mirrors the SEP rights that are available to individuals offered a non-calendar-year Individual Coverage Health Reimbursement Arrangement (ICHRA).

### **Termination of Coverage - §155.430**

Our members support the two proposed changes to the termination of coverage provisions in §155.430. One relates to the termination of coverage for Medicare-eligible individuals to align it with proposed changes to §155.330. The other would align the termination effective date in cases of retroactive termination of coverage due to exchange-based errors with the retroactive termination dates used in all other cases.

### **Eligibility Pending Appeal - §155.525**

The proposed rule asks for opinions as to if people who are appealing an exchange-based eligibility determination and are eligible for coverage pending their appeal should be allowed to pick any plan option or from a limited menu of plan options. NAHU members believe that appellants who elect coverage pending an appeal should have freedom of choice when selecting a QHP. Furthermore, we support CMS's proposal to allow these individuals an additional 30 days of post-appeals-related coverage selection to request a tax credit eligibility determination. Finally, should an appellant not pay premiums, we do not think that they should be treated any differently than any other typical exchange enrollee concerning coverage termination.

### **Quality Rating Information Display Standards for State-Based Exchanges - §155.140-155.145**

NAHU members support the proposed regulatory changes to allow state-based exchanges the flexibility to include state-specific or other specialized information in their quality rating information for consumers.

### **Annual Reporting of State Benefits - §156.111**



The proposed rule would require each state to annually report on state benefit mandates that exceed the ACA's essential health benefit (EHB) requirements. For the first reporting year, states would have to report on all benefit mandates that exceed the EHB standards enacted after December 31, 2011. In all subsequent years, a state would only need to report on any new mandated benefit requirements that exceed the EHB threshold. This reporting would follow a standardized, CMS-driven format, and CMS would develop templates for states.

NAHU agrees with this requirement, which should improve transparency and help ensure that exchange subsidies are calculated and used appropriately. Our association believes that the individual states are the most appropriate entities to do the reporting, and we do not think that it is necessary to allow for a public comment period before publicizing state reporting. However, we suggest that CMS develop a procedure to use, should there ever be a mistake in a state's mandated benefit reporting.

#### **Requirements for Timely Submission of Enrollment Reconciliation Data - §156.265**

The proposed rule would require health insurance issuers to follow explicit requirements to verify exchange enrollment records and better ensure their accuracy. NAHU supports the provisions that would require an issuer to submit the latest available verified enrollment information in its enrollment reconciliation submissions and inform the exchange of any errors within 30 days. We also support CMS's effort to lengthen the timeframe that issuers have to report consumer payment errors from 15 days to 90 days. We agree that extending this reporting timeline will give insurers more time to research, report, and correct inaccuracies. If the exchanges have access to the most current and accurate enrollment data from issuers, it will help everyone involved in assisting consumers. Additionally, it may help improve the accuracy of any eventual IRC §4980H penalty assessments levied by the Internal Revenue Service, as they rely partly on exchange enrollment data.

#### **Prescription Drug Coupons/Accumulator Adjustment Program - §156.130**

The proposed rule would establish that health insurance issuers, including both fully insured group health insurance carriers and self-funded employee benefit plans, are not required to count any coupons from drug manufacturers toward a consumer's out-of-pocket limit unless state law specifies otherwise. The proposed rules also would amend the definition of "cost-sharing" to allow issuers to exclude the value of any drug manufacturer coupon or cost-sharing assistance from an enrollee's deductible.

This policy change is concerning to NAHU. We understand that the practice of drug manufacturers subsidizing consumer costs for brand-name drugs does, in many cases, keep prescription drug costs artificially and often unreasonably high. However, the policy change in the proposed rule does nothing to target the real source of the problem: the drug manufacturer. Instead, it targets consumers merely for having a medical condition that requires treatment through a high-cost prescription drug. If CMS objects to the existence of manufacturer cost-sharing assistance programs, it should address them at their source. We also note that a related proposal in the 2020 Notice of Benefit and Payment Parameters that was later modified by subsequent sub-regulatory guidance resulted in substantial confusion for employer-sponsored group benefit plans. How to handle the requirement in cases of employees enrolled in HSA-qualified high-deductible health plans was of particular concern.

Our association appreciates the stipulation that issuers considering adopting the practice of excluding any value an enrollee may obtain from a prescription drug manufacturer's cost-sharing assistance program should disclose this practice on all websites, brochures, plan documents and other collateral materials. If you finalize this proposal, the



disclosure will be essential for consumer protection and decision-making. It is also the type of information that employer plan sponsors have a fiduciary duty to disclose to all plan participants in their ERISA-required plan documents, including the SPD. NAHU suggests that any final rule that includes a version of this policy should specify that issuers that elect exclusion are required to note it on their summary of benefits and coverage and in their SPD. Further, the final rule should contain explicit guidance about how this requirement will work for people who may enroll in an HSA-qualified high-deductible health plan.

### **Promoting Value-Based Insurance Design**

The proposed rule does not create any new requirements for exchanges or issuers related to value-based insurance design. However, it does request some information about ways in which CMS can promote coverage with value-based components. To distinguish value-based plans as part of the QHP option display, CMS may want to consider the use of a defined special symbol. Also, NAHU believes it would be beneficial if the CMS training for certified brokers, as well as CMS training for other assisters, includes additional information about value-based coverage. As for how CMS and issuers could determine if plan designs meet value-based criteria, the proposed rule contemplates the determination of specific minimum standards. The development of such measures might be a task best appropriate to the National Association of Insurance Commissioners. Finally, to incent the development of value-based QHP products, NAHU suggests specific medical loss ratio relief for insurers that engage in this endeavor.

### **Termination of Coverage for Qualified Individuals - §156.270**

NAHU supports the proposed change to existing requirements to send a termination of coverage notice to qualified terminated individuals. Currently, in certain instances, people do not receive a termination of coverage notice from the exchange marketplace. If finalized, the new rule would clarify and simplify the termination rules to notify all affected people.

### **Medical Loss Ratio Requirements - §158.150**

NAHU supports the proposed change to the medical loss ratio (MLR standard) to allow individual market insurers to include the cost of specific wellness incentives as quality expenses in their MLR calculation. This proposal mirrors existing allowances for group market insurers.

We sincerely appreciate the opportunity to voice our viewpoint on the proposed rule. We are also grateful for your commitment to gathering the views of all stakeholders about these critical topics. If you have any questions about our comments or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or [jtrautwein@nahu.org](mailto:jtrautwein@nahu.org).

Sincerely,

A handwritten signature in black ink, which appears to read "Janet Stokes Trautwein".

Janet Stokes Trautwein  
CEO

National Association of Health Underwriters