American Hospital Association

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December 30, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

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 Waiver) Implementing Regulations (CMS-9914-P)

Dear Administrator Verma:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 90 that offer health plans, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, we thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Notice of Benefit and Payment Parameters for 2022.

The AHA remains committed to ensuring that consumers have access to comprehensive, affordable coverage through the marketplaces and is concerned that several proposals could jeopardize progress that has been made toward this goal. Specifically, we urge the agency not to finalize proposals that would allow states to create a new type of direct enrollment marketplace in lieu of Healthcare.gov or a state-based marketplace. In addition, we do not support the codification in regulation of previous Section 1332 guidance that could allow states to pursue alternative approaches to coverage that would result in coverage losses.

Comprehensive, affordable coverage is critical to patients' access to care, and the Health Insurance Marketplaces remain the best option for individuals searching for comprehensive individual market coverage or Medicaid. These platforms create one-stop shops for individuals to determine their Medicaid or premium tax credit eligibility and shop for, and enroll in, comprehensive plans that meet all of the consumer

protections required under federal law. By design, these platforms display equally all qualified health plans (QHPs) offered in the region and do not include any substandard products, such as short-term, limited-duration (STLD) health plans. This gives shoppers on Healthcare.gov or state marketplaces the confidence of knowing they are purchasing a comprehensive health plan without the risk of being confused or misdirected by marketing of products that do not offer similar coverage. **For these reasons, states should not be permitted to discontinue their use of Healthcare.gov to instead rely on private entities that are not held to such rigorous standards**.

The AHA remains committed to continuing to improve the marketplaces, including making the plans sold on the marketplaces more affordable. Among the concepts AHA supports are federal and state reinsurance programs that help reduce the cost of coverage, increased eligibility for, and generosity of, subsidies, and increasing outreach and enrollment assistance since most uninsured individuals are already eligible for some form of subsidized coverage. These approaches retain vital consumer protections while supporting greater enrollment. They also reduce health care costs by bringing greater balance to marketplace risk pools.

Our detailed comments on the proposed rule follow.

DIRECT ENROLLMENT

CMS seeks comments on a proposal to allow states to establish a new type of marketplace that relies on direct enrollment websites, rather than Healthcare.gov or state-based marketplaces, for consumer shopping, application, and enrollment. CMS argues that allowing private sector entities, such as issuers, web-brokers, agents and brokers, to perform these functions instead of the government would "enhance the consumer experience" and incentivize these actors to invest more in a robust enrollment process than they have to date, as they will no longer have to compete with the government platform. CMS believes this will lead to a better consumer enrollment experience because individuals will have more options as to where they shop and the types of plans available to purchase.

However, such arguments fail to recognize that more is not always better and the availability of many different websites offering enrollment in various subsets of private, individual market plans (including both QHPs and non-complaint plans) is likely to result in more consumer confusion. **We strongly disagree that this fragmented, private sector approach is a better option for consumers than the centralized marketplaces that exist today, and we urge CMS not to finalize this proposal.**

Consumers already have access to various forms of direct enrollment if they are interested in using brokers or shopping outside of the marketplaces. The real impact of this policy would be removing the availability of a one-stop shop where consumers could fill out a single application to determine their eligibility for public programs, such as Medicaid or premium tax credits, search all available QHPs in a standardized format,

and enroll in their chosen plan. This new type of marketplace would disaggregate this process in a few significant ways.

First, direct enrollment websites are not required to sell all available QHPs. This means that individuals would need to search through multiple websites – instead of just one – to ensure they were choosing the best plan for themselves or their families. These websites also cannot facilitate enrollment in public programs such as Medicaid or the Children's Health Insurance Program. This adds additional enrollment steps for individuals deemed eligible for such programs. These complications will inevitably discourage some individuals from completing the enrollment process. Others likely will dis-enroll and become uninsured as their eligibility for public programs or premium tax credits change. Though not addressed in the rule, this policy also raises questions about how automatic reenrollment would occur through these private sites. **It is of utmost importance that we build upon, rather than dismantle, auto-reenrollment strategies.**

In addition, unlike the marketplaces, direct enrollment websites are able to steer individuals to certain plans. Unfortunately, this steering can be heavily influenced by what is best for the direct enrollment entity, not the individual. A recent study found that, on average, brokers receive a 23% commission for the sale of STLD health plans, compared to an average 2% commission for Affordable Care Act (ACA)-compliant plans. As we've commented previously, these types of non-compliant plans do not provide adequate access to care and can subject consumers to greater out-of-pocket spending when illness or injury occur. But these are the types of plans that are typically marketed more prominently on direct enrollment sites. Policies that ban these types of plans from being displayed side-by-side with ACA-compliant plans are unlikely to help; the display for this type of plan is often more robust and prominent on these sites, making the ACA-compliant plans harder to find.

In addition, the information that individuals fill out on direct enrollment sites is often used to further market, through email and phone calls, plans that pay high commissions but provide substandard coverage. The language on these sites also can be confusing and misleading, making it hard for consumers to navigate. This can lead to individuals enrolling in plans they believe to be more comprehensive, or unintentionally forgoing premium assistance or public programs that they are eligible for, because the websites encourage enrollment in plans that will pay higher commissions.

Now, more than ever, it is important that individuals are able to easily find and keep comprehensive health care coverage. This proposal leads us in the wrong direction, making it harder for individuals to find the right plan and less likely that they would stay enrolled year-over-year. It also would contribute to instability and higher premiums in the individual market by encouraging younger, healthier individuals to purchase non-ACA compliant plans, which would then take them out of the individual market risk pool. **We urge the Administration not to finalize this proposal.**

STATE INNOVATION WAIVERS

CMS, in coordination with the Department of Treasury, also seeks comment on a proposal to codify its October 2018 guidance on State Innovation Waivers (83 FR 53575). As we have commented previously, we have a number of concerns that the guidance as written could depreciate the quality and affordability of health care coverage in the states that take advantage of these flexibilities. For example, the guidance allows states to encourage the expansion of health plans that do not meet all of the consumer protections established in federal law, including STLD health plans. As detailed above, these types of plans provide inadequate coverage and can destabilize the fully compliant individual market.

The guidance also adopts a principle to promote "consumer-driven health care," which we understand to mean plans that use higher cost sharing to influence patients' decisions about whether and where to access care. Recent studies and years of anecdotal evidence from AHA members show that such plans can have significant negative consequences on patients' access to care and have steep, unexpected financial implications.

Hospitals and health systems are committed to states' flexibility; however, the revised guidance goes too far in allowing states to take actions that could result in weakened consumer protections and the destabilization of the individual health insurance market. **We urge the departments not to codify this guidance and instead update the guidance to ensure that alternative approaches to coverage increase, instead of reduce, enrollment in comprehensive coverage.**

MAXIMUM ANNUAL LIMIT ON COST-SHARING

CMS proposes to update the premium adjustment percentage, which would result in maximum annual limits on cost sharing in 2022 to $9,100 for self-only coverage and $18,200 for family coverage. **The AHA remains deeply concerned that these out-of-pocket limits are unsustainable and would leave patients vulnerable to financial hardship.**

As we discussed above and commented previously, it is well documented that the increase in consumer financial responsibility for health care services, particularly through the rise of high-deductible health plans (HDHPs), is a growing problem in this country. The most recent Federal Reserve report on the economic well-being of U.S. households, completed before the current economic crisis, revealed that 37% of adults would not be able to afford a $400 emergency, an amount less than 5% of the proposed individual limit. The same report found that over 20% of adults reported unexpected medical bills with median expenses between $1,000 and $1,900. In addition, 25% of adults reported skipping medical care due to an inability to pay, including 43% of adults who reported being in poor health.

Plans with such high cost exposure leave patients underinsured and unable to afford their care. This harms not only the patient but the financial stability of the hospitals and health systems that serve them. We have heard from our members that more than 50% of charity care is now supporting insured (or rather, underinsured) patients, rather than uninsured patients. The proposed increases to the annual limits on cost sharing will only perpetuate this trend and should be reconsidered.

USER FEE RATES

CMS seeks comment on the appropriateness and type of potential alternative revenue sources in place of the user fees. **The AHA questions how the Health Insurance Marketplaces will have the financial resources to perform key responsibilities, including outreach and enrollment and infrastructure maintenance, without user fees.** We also are perplexed by the suggestion that the marketplaces do not provide sufficient value to health plans (and, presumably, consumers) to warrant the cost. The marketplaces have dramatically expanded business opportunities for many health plans – to the tune of billions of dollars in profit each year – and provide critical information and enrollment support for consumers. As CMS notes, the services provided by the marketplaces go above and beyond those typically performed by agents and brokers, which issuers have historically paid to market and sell their products, to also ensure regulatory compliance. This infrastructure must be maintained and adequately supported.

For these reasons, health plans should remain responsible for paying user fees. To the extent efficiencies can be found without compromising the quality of services, we would support policies that lower the user fees. However, we do not believe CMS has provided evidence to support reductions at this time, especially as we face two years of coverage losses through the marketplaces and anticipate greater demand for marketplace coverage as the economic crisis caused by COVID-19 continues to reduce the availability of employer-sponsored coverage. In addition, we do not think alternative funding sources are appropriate or needed at this time.

SPECIAL ENROLLMENT PERIOD VERIFICATION

CMS seeks comment on its proposal to require all states, including those with state-based marketplaces, to conduct special enrollment period (SEP) verification on at least 75% of new marketplace enrollees that enroll during a SEP. The 2017 marketplace stabilization rule required states using the federal platform to perform pre-enrollment eligibility verification for certain SEPs, but did not impose such requirements on state-based marketplaces. Instead, the agency encouraged states running their own marketplaces to implement similar rules on their own. As CMS notes in the rule, all state-based marketplaces since that time conduct either pre- or post-enrollment verification for at least one type of SEP. This proposal would make pre-enrollment verification mandatory for state-based marketplaces. Given the pre- and post-enrollment validations already happening in these states, the AHA questions the need for these

additional regulations. Furthermore, at a time when accessing health care coverage is crucial, we are concerned about any policies that could impose unnecessary barriers to enrollment for an eligible individual. **Therefore, if CMS chooses to finalize this proposal, we encourage the agency to include additional guardrails to minimize the level of burden this would impose on individuals seeking enrollment, as well as states that are grappling with significant financial constraints as a result of the economic crisis brought on by COVID-19.**

We appreciate the opportunity to comment on the policies proposed in the 2022 Notice of Benefit and Payment Parameters. The AHA is committed to maintaining adequate access to comprehensive, affordable coverage on the marketplaces and looks forward to working with the agency on these objectives. Please contact me if you have questions, or feel free to have a member of your team contact Ariel Levin, AHA's senior associate director of policy, at (202) 626-2335 or alevin@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis & Development