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February 19, 2019

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 2020 (CMS-9926-P)

Dear Ms. Verma:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, including nearly 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 2020. **The AHA remains committed to ensuring that consumers have access to comprehensive coverage through the marketplaces and looks forward to continuing to work with the agency on this objective.**

Comprehensive coverage is critical to patient access to care. We are pleased that the agency did not propose to make immediate policy changes in a number of areas that could reduce consumers' access to coverage, including changes in policy regarding auto-reenrollment and "silver-loading," but instead chose to seek comment on potential future actions. We also appreciate the agency's interest in increased transparency in consumers' health coverage as the AHA shares in this important goal. CMS has substantial authority to improve and conduct more rigorous oversight of both provider networks and directories to facilitate consumer shopping and avoid surprise medical bills resulting from unanticipated gaps in coverage. However, we are concerned that several of the provisions could result in a loss of coverage or the erosion of key consumer protections.

Our detailed comments follow.



TRANSPARENCY

In its proposal, CMS seeks comments on ways to increase consumer transparency in regards to their health coverage, including their out-of-pocket cost obligations, and their health data. We support the agency's commitment to ensuring "consumers have access to relevant, consumer-friendly information that is meaningful to them," and look forward to working together on this shared goal. The agency specifically seeks comments on the following areas.

Qualified Health Plan (QHP) Selection. The agency seeks comments on the types of data that would be most helpful in improving consumers' abilities to make informed coverage decisions. **Based on the experience of our members and the patients they serve, we urge CMS to increase oversight and enforcement of health plan provider network and directory standards.**¹ Consumers often select their coverage based on whether their preferred provider is in a plan's network, and they rely on directories to identify a provider's network status. Too often, provider directories are out-of-date or missing information, making it difficult for patients to make informed decisions about their care. Our members have reported instances where health plans have advertised their networks during open enrollment as including certain hospitals and health systems when that is not the case. These inaccuracies can lead to unexpected out-of-network care and surprise medical bills.

In addition, provider directories should, but often do not, include information on a physician or other care provider's affiliations with certain hospitals. Without this information, patients preparing for a health care procedure cannot fully assess whether or not the full scope of their care will be in-network, a scenario that also can lead to surprise medical bills for out-of-network care.

However, simply having accurate provider directories will not fully protect patients from unexpected gaps in coverage that can lead to surprise medical bills and up-end transparency efforts. We encourage CMS to strengthen the network adequacy rules to ensure that plans have taken into account whether the in-network physicians practice at the in-network facilities. We increasingly hear of incidences where health plans report to have in-network certain hospital-based specialists only for consumers to find out that none of the network specialists practice at the in-network hospitals.

Price Transparency. CMS seeks comments on ways to improve consumers' access to information on health care costs. We are acutely aware of the challenges patients may experience when seeking information on the cost of their care, as hospitals, not health plans, are often where patients turn when looking for this information. While the uncertain nature of health care is one fundamental challenge, another is that patients and their providers do not always have easy access to information on how the health plan will assess cost-sharing for a particular service. Specifically, while it's logical from

¹ 45 CFR § 156.230(b)

the patient's perspective to ask their care providers for cost information, providers often lack key information about the patient's insurance. While some mechanisms exist to make such information available to hospitals and health systems, they frequently do not work. For example, our members report that the standard eligibility transaction could, if returned from the health plan fully completed, provide much of this information. However, the health plans' response often is limited to "yes/no" about whether the individual is covered for the service. It does not include more detailed cost-sharing information. At that point, hospitals and health system staff must rely on a more manual process – calling the health plan for a one-on-one discussion about a patient's coverage. This is not a scalable solution if the objective is to promote widespread access to timely, accurate and personalized cost-sharing information.

To help resolve this issue, we encourage the agency to: (1) ensure that health plans are complying with 42 USC § 18031(e)(3)(C), which requires QHPs to provide enrollees with accurate cost-sharing information (including deductibles, copayments and coinsurance) for a specific item or service by a participating provider via a website and in a timely manner; and (2) to interpret the statute to require that health plans make this information available directly to providers so that they can assist patients when they receive inquiries. If the information required by this statute was available readily to providers via a web-link, it would increase access to relevant, consumer-friendly pricing information.

Hospitals and health systems are committed to helping patients understand their expected costs as they plan for a health care service or procedure. Access to this information via the websites referenced above and fully completed standard eligibility transactions would help our members respond accurately and in a timely manner to patients' inquiries about the out-of-pocket price of their care.

Barriers to Private Price Transparency Efforts. CMS also seeks comments on ways that the agency can better support privately-led efforts to address price transparency. One barrier relates to the ability of providers to disclose the negotiated rates between the hospital and health plan in advance of providing care. Many hospitals are developing consumer-friendly tools that allow patients to look up a cost estimate for a health care procedure based on their specific insurance information. These tools can provide patients information on both their expected out-of-pocket costs, as well as the total possible cost, based on the negotiated rate. Providing the full negotiated rate helps negate any surprises for patients. Even though the patient is unlikely to pay the total amount, providers have found that it is helpful to provide this information, especially if the cost-sharing information is inaccurate for any reason. The total cost provides the patient with a ceiling – it is the maximum amount the patient could expect to pay. Unfortunately, health plans are not always willing to have hospitals share this information with patients, citing contractual terms. While the health plans provide this same information to the patient *after* the procedure through the explanation of benefits, they are not allowing patients to obtain this information *prior* to the procedure, handicapping price transparency efforts. **To the extent possible, we encourage CMS**

to provide guidance to hospitals and health plans on ways to work together to ensure that meaningful innovations in price transparency can be successful.

Interoperability. With respect to interoperability and sharing of health data, hospitals and health systems are committed to making the right information available in the right place and at the right time to provide the best care and engage patients in their health. They have invested significant financial and staff resources to capture and share information from clinical care in electronic health records (EHRs) and other forms of health information technology, resulting in significant progress. Today, 93 percent of hospitals and health systems make records available to patients online and 88 percent regularly share records with ambulatory care providers outside of their system. However, more needs to be done. The AHA, together with six other national hospital associations, recently released a report, [Sharing Data, Saving Lives: The Hospital Agenda for Interoperability](#). The report identifies six pathways to advance interoperability, which includes, among others, connecting information beyond EHRs, such as patient-generated data or claims information. It also outlines steps that various stakeholders, including health plans, can take. Generally, health plans have access to a more complete picture of the services an individual has received than any individual health care provider. **Therefore, we strongly encourage CMS to focus on how both consumers and providers can get easy, timely and complete access to health care data from plans participating in the marketplaces as it engages in future work on interoperability.**

PRESCRIPTION DRUGS

CMS seeks comment on provisions related to prescription drug benefits with the intent of lowering drug prices for marketplace consumers. The AHA is deeply committed to addressing the prescription drug spending crisis that puts patient access to care in serious jeopardy. We point CMS to a recently released [report](#) by the NORC at the University of Chicago that details hospital and health systems experiences with drug prices and shortages.

The AHA supports several of the proposed provisions but urges caution to ensure that patient's maintain access to critical drug therapies, and are not unduly at risk for unexpected high out-of-pocket costs. The AHA supports allowing plans to make mid-year changes to their formularies if a generic-equivalent becomes available. Such changes should support adoption of lower-cost alternatives, therefore reducing out-of-pocket costs for consumers, as well as premiums. However, if finalized, we urge CMS to maintain and enforce important consumer protections. Patient safety and access to high quality care are top priorities for the AHA and its members. We urge CMS to protect continuity of care for patients and provide for coverage of a drug deemed medically necessary for a specific patient. In addition, we expect the agency will continue to protect patients in need of certain drugs through a robust and timely appeals process.

The AHA also supports the agency's proposal to curb the use of drug manufacturer coupons. Drug manufacturers use discount cards to promote brand-name drugs even when lower-cost generics are available. These are really a "bait-and-switch" scheme where discount cards reduce patients' out-of-pocket spending in the short term until the discount is no longer valid. When the coupon expires, it means the patient has to pay higher out-of-pocket costs in order to continue the drug regimen for the long term. Meanwhile, costs for insurers – and therefore premium prices for consumers – are inflated. Further, the use of discount coupons does nothing to address the core issue of increasing drug prices overall.

Additionally, the AHA supports the intent of the agency's proposal to permit issuers to not count the difference between brand and generic cost-sharing toward the annual cost-sharing limit. Encouraging the use of generic drugs over costly brand name drugs, when available and medically appropriate, will allow consumers to be more involved in the decision-making process and can reduce out-of-pocket spending. However, the AHA is able to support this proposal only insofar as the agency establishes and maintains strong safeguards and conducts rigorous oversight to ensure patient protection. Specifically, any plan that implements this option should first identify and engage patients who could be subject to this policy and provide them with education about the implications of not switching products. In addition, we support CMS's requirement that participating plans include an exceptions process for those patients requiring brand name prescription drugs due to medical necessity and emphasize that this provision also should include continuity of care-related requests. We further expect the agency will continue to protect patients in need of certain drugs through a robust and timely appeals process.

Finally, while we appreciate the intent of CMS's referenced-based pricing proposal, we are concerned that it does not directly address manufacturer price inflation and, instead, would put hospitals and physician practices at risk for price differences between drugs that may or may not be "therapeutically similar" for individual patients. That is, patients' medical conditions are not uniform; a drug that is effective on average may be ineffective, or even dangerous, for a particular patient. In addition, this approach assumes that, by setting a benchmark price based on the average for the drugs in the group, or based upon the most-effective drug in the group, manufacturers would have an incentive to lower their price below their competitors in order to make their product more attractive and garner market share. However, one also could foresee just the opposite happening. That is, a manufacturer with a product priced below the benchmark could reason that there would be no harm in increasing its price to the average rate so as to maximize profits. This would have the impact of driving the average up and increasing overall spending for drugs in the group.

SILVER LOADING

CMS expresses concerns with the practice of "silver loading," where health plans raise silver plan premiums to finance the statutorily-required but unfunded cost-sharing

reductions (CSR). In doing this, health plans concentrate the necessary premium increase in one type of plan, allowing consumers to avoid the additional premium costs if they choose a non-silver plan, such as bronze or gold. While not taking any action at this time, the agency notes its support of a legislative solution to provide appropriate funding for the CSR payments, thus eliminating the need for health plans to silver load. The agency, however, seeks comments on whether to take action on its own to address this issue should Congress fail to act. Any future action would occur through the notice-and-comment rulemaking process.

The AHA strongly supports congressional action to fund the CSRs. Absent legislative action, we oppose any administrative action to prohibit silver loading.

Fully funding the CSR payments would help to ensure the stability and affordability of the marketplaces. As the agency notes, without these payments, health plans face an additional cost that ultimately gets passed back to the consumer through higher premiums. Today, health plans in states that allow silver loading are able to protect consumers by limiting the premium increases to silver plans. Subsidized consumers who enroll in the higher-cost silver plans are protected from the increase because the tax credit increases correspondingly. As previously mentioned, unsubsidized consumers are able to purchase gold or bronze level plans without experiencing the impact on their premiums. Spreading the cost across all plans would raise the cost for both subsidized and unsubsidized enrollees and may create a cost barrier for some consumers. We urge the agency not to threaten consumers' access to coverage or the stability of the marketplaces by taking any action to address silver loading.

AUTOMATIC RE-ENROLLMENT

CMS seeks comment on whether to continue to allow automatic re-enrollment, which currently occurs when marketplace enrollees take no action during open enrollment to dis-enroll or select a new plan. During the recent 2019 open enrollment period, 1.8 million people in states relying on federally-facilitated exchanges were automatically re-enrolled. One of the agency's concerns with this practice is that it dis-incentivizes consumer engagement. The agency assumes that, without this practice, consumers will become better shoppers and look for the best plan that meets their needs. However, this may not be the case. These consumers have the option to shop for the best plan for themselves and their families already and are choosing not to for various reasons. Taking away automatic reenrollment risks dropping millions from coverage who ultimately do not re-enroll. Moreover, losing these individuals in the insurance risk pools could have a detrimental effect on the stability of the marketplaces, further putting coverage at risk.

As we detail in the [AHA Fact Sheet on the Importance of Coverage](#), health care coverage is essential for an individual's physical, mental and financial health, as well as the health of the community. **Maintaining the coverage gains made over the last decade is vitally important to the health of patients, communities and the**

hospitals and health systems that care for them. We urge the agency not to take action in the future that could cause a significant setback.

As an alternative, we encourage the agency to provide more resources to help inform consumers about their coverage options. Specifically, we encourage the agency to sufficiently fund outreach and enrollment efforts. These resources are vital sources of information for individuals on how to shop for, enroll in and use their health care coverage. Such assistance is particularly needed in vulnerable communities with traditionally low health care literacy. As part of this, we encourage the agency to maintain the robust portfolio of the navigators to ensure that they are equipped to meet consumers' needs. Please see the navigator section for additional comments on this topic.

PREMIUM ADJUSTMENT PERCENTAGE

CMS proposes to change the methodology for calculating the premium adjustment percentage to include individual market premiums in the calculation. Currently, CMS calculates the premium adjustment percentage using employer-sponsored insurance premiums. CMS proposes this change to more accurately reflect premium trends across all private health insurance markets. This change would result in higher out-of-pocket premium costs for subsidized individuals and a higher annual limit on cost sharing in both the individual and group market. The agency calculates that this would result in 100,000 fewer enrollees in the marketplaces in 2020. **The AHA encourages CMS not to adopt this change at this time.** The marketplaces have begun to demonstrate signs of stability, and this change could undo this progress by creating a cost barrier for consumers. We encourage the agency to not move forward with this proposal at this time.

NAVIGATOR PROGRAM

CMS proposes to scale back some navigator functional and training requirements, making it optional for navigators to provide post-enrollment assistance and reducing the current training requirements to four areas. Previously, grantees were required to undergo training on 20 specific topics. The agency argues that these changes will give navigators greater flexibility to focus on the critical needs in their communities in light of limited resources for the program. The agency has chosen to limit resources annually, with funding for the program down to only \$10 million in 2018, from almost \$63 million in 2016 and \$36 million in 2017. In other words, since 2016, funding for the program has been cut by 84 percent.²

The AHA is concerned about the direction the agency is taking with respect to consumer outreach and education and marketing of marketplace coverage. Navigators

² The Center for Consumer Information & Insurance Oversight, In-Person Assistance in the Health Insurance Marketplaces, Funding Opportunity Announcements and Grant Recipients.
<https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html>

are an important source of information for communities that may not otherwise be reached through traditional outreach. Navigators play a key role not only in helping individuals shop for and enroll in a health plan, but also providing education around what insurance is and how to use coverage once enrolled. For example, in addition to encouraging consumers to shop for the best coverage for themselves, navigators also can help them learn how to evaluate the differences among health plans, including estimating their total out-of-pocket costs, ultimately facilitating more consumer engagement. The proposed changes could limit the types of consumer-friendly information available, negatively impacting the ability of individuals in vulnerable communities to get and use coverage. **We encourage CMS not to move forward with this proposal and instead restore full funding to the navigator program at the 2016 level so that navigators are able to perform adequately all enrollment and post-enrollment responsibilities, including supporting consumer engagement in the purchase and use of coverage.**

ESSENTIAL HEALTH BENEFITS

In the Final Notice of Benefit and Payment Parameters for 2019, CMS provided states with three additional options for selecting Essential Health Benefits (EHB) benchmark plans, beginning in the 2020 benefit year. In the proposed rule, CMS encourages states to consider using one of the new options. **We appreciate the agency encouraging states to address the opioid epidemic through the new EHB flexibilities, by including in the benchmark plan alternative therapies for chronic pain and expanding coverage of mental health and substance use disorder treatments.** We agree with the agency's encouragement of health plans to cover medication-assisted treatment, even if it is not included in the state's EHB benchmark plan, and the reminder that covering certain treatments for some medically-necessary purposes, but not for opioid use disorder treatment, could be discriminatory.

However, as the AHA has [commented](#) previously, we remain concerned that these new options would reduce the benefit packages, leading to patients facing increased out-of-pocket costs for services that are no longer covered and that would not be subject to cost-sharing limits or prohibitions on annual or lifetime limits.

RISK ADJUSTMENT

State Flexibility Request. For the 2020 benefit year, the state of Alabama is requesting from CMS the flexibility to reduce its small group risk-adjustment transfer by 50 percent to account for the presence of a dominant carrier in its small group market. **We support this proposal and encourage CMS to allow Alabama to reduce its risk-adjustment transfer in the small group market by 50 percent.** Each state's insurance department is best positioned to assess the market dynamics in its state. We believe Alabama makes a compelling case based on the overwhelming dominance of one carrier in the market. The requested flexibility would allow Alabama to protect its market from further erosion of competition in the small group market.

RADV Requirements. The Department of Health and Human Services requests comment on the impact of the current risk-adjustment data validation (RADV) program error estimation methodology and the outlier adjustment policy for carriers with significantly lower HCC failure rates (“negative outliers”) on other carriers in a state market risk pool, the incentives negative error rate adjustments create and potential changes to such policies. **For 2017, RADV applied to 2018 risk-adjustment results, we support the current general policy adjusting both positive and negative outliers to an average risk score. We further recommend determining settlements without adjustment to the sampling process. Consistent with risk adjustment’s broader policy goals, this approach encourages timely settlements with financial transfers that reflect actual differences in issuer risk.** A balanced and credible alternative to the present RADV methodology’s treatment of positive outliers has not emerged. At this stage, further delay of RADV implementation (contrary to issuer expectations) would be unreasonable and fundamentally jeopardize risk adjustment’s programmatic integrity. The methodologies for risk adjustment and RADV are both imperfect, and we acknowledge that any methodology can be improved. Nevertheless, any changes should be inclusive of risk adjustment globally and implemented in an orderly and purely prospective manner with the intent to continue soliciting input and incorporating future refinements as necessary. Midstream failure to implement a single element of risk adjustment (e.g., RADV) could introduce additional market volatility equal to or surpassing the impact of implementation as originally planned.

We appreciate the opportunity to comment as CMS considers policymaking in a number of key areas. The AHA is committed to maintaining adequate access to care and 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, senior associate director of policy, at (202) 626-2335 or alevin@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy