American Hospital Association

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October 5, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-9934-P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018

Dear Mr. Slavitt:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations (more than 100 of which sponsor health plans), and our 43,000 individual members, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed Notice of Benefit and Payment Parameters for 2018.

The AHA appreciates CMS's proposals to improve the stability of the Health Insurance Marketplaces, such as refinements to the risk-adjustment program. The stability of the public marketplaces is critically important to consumers, health plans and providers alike. Both plans and their network providers depend on functioning insurance markets to ensure consumer access to affordable coverage. At its core, marketplace stability is predicated on broad consumer enrollment. And in order for the marketplaces to be attractive to consumers, they must offer affordable coverage and choices that meet consumer needs. **In addition to the changes proposed by CMS, we recommend further actions the agency may take to stabilize the marketplaces. These include explicitly requiring plans to accept premium payments from hospitals, hospital-affiliated foundations and other charitable organizations.**

RISK ADJUSTMENT

CMS proposes a number of changes to the risk-adjustment program, largely consistent with the agency's March 2016 white paper. Specifically, the agency proposes to refine the adult risk model to account for partial-year enrollments, to incorporate a small number of prescription drug classes to impute missing diagnoses and indicate severity of illness, and to remove some costs associated with high-cost enrollees (those with more than $2 million in costs annually) who may

skew the overall risk-adjustment score. **We concur with CMS's proposals related to the risk-adjustment program and believe such changes will result in a fairer payment methodology for health plans. However, we encourage CMS to monitor, if finalized, the adjustment for high-cost enrollees to ensure that it does not inadvertently harm plans.** CMS does not propose to use new funds to cover its share of the costs for the enrollees with claims greater than $2 million. Rather it would divert funds from within the risk-adjustment program to finance these claims. If finalized, we urge CMS to monitor the impact of this modification to ensure that it does not weaken the effectiveness of the overall risk-adjustment model by diverting a significant portion of the dollars.

CMS also proposes to begin collecting enrollee-level data from health plans for purposes of recalibrating the risk-adjustment model. This would be a new data collection of potentially highly sensitive personal health information at the individual level. CMS proposes to collect and store this data centrally. Given the increased cybersecurity threats within the health care sector, we are very concerned that such a data collection could put millions of Americans at risk for a security breach. **We ask that the agency refrain from moving forward with such data collection until additional information is available, including the specific enrollee-level data the agency intends to collect, the scope of the use of the data, and the protections the agency will put in place to ensure security of the data.** Without this information, we are unable to assess whether such a data collection is required beyond the existing distributed data collection model and warrants the increased security risk.

SPECIAL ENROLLMENT PERIODS (SEPS)

CMS proposes to codify in regulation several SEPs that it made available in prior guidance. The agency does not propose any changes to the SEP verification process, but instead seeks comment on a number of issues related to the use of SEPs, including both potential abuses and barriers to use.

The AHA is disappointed that the agency did not propose a pre-enrollment verification process, which we believe would prevent potential misuse of the SEPs. However, we appreciate that the agency is planning to launch a pre-enrollment verification of SEP eligibility pilot in 2017. We believe this pilot is an important step in defining the parameters of a pre-enrollment verification process. For example, the agency may test whether covering certain services, such as preventive care, should be allowed while verification is pending or whether a standard "waiting period" should be included as part of the eligibility review process. We point CMS to our comments on the proposed pilot project for more detailed recommendations.

NETWORK ADEQUACY STANDARDS

CMS recently announced that it will launch, via a pilot, a network breadth indicator in certain states on *HealthCare.gov*. This indicator will denote a qualified health plan's (QHP) relative network coverage and will be displayed in the plan comparison tool. In this rule, CMS considers whether it should incorporate more detail into these indicators, specifically, whether to indicate if a plan is offered as part of an integrated delivery system.

We appreciate CMS's goal of continuing to improve consumer information about plan networks and agree that the agency should explore whether identifying plans that are part of an integrated delivery system helps consumers make more informed decisions.

'SURPRISE' BILLS

In an attempt to minimize "surprise" bills for marketplace enrollees, CMS made several policy changes in the Notice of Benefit and Payment Parameters for 2017. Specifically, CMS required plans to count enrollee cost sharing for an essential health benefit (EHB) provided by an out-of-network provider toward the enrollee's annual limitation on cost sharing beginning in 2018. Alternatively, CMS allowed health plans to provide enrollees with a written notice in advance of receiving the service that provides sufficient information on the implications for choosing to receive care from an out-of-network provider so that the enrollee can make an informed choice. In this rule, CMS proposes to apply this policy to QHPs both on and off the marketplaces, regardless of whether the QHP covers out-of-network services. CMS also requests feedback on other policy changes that could limit surprise bills for consumers.

While the AHA appreciates CMS's efforts to protect consumers who receive covered services from out-of-network providers, we believe CMS's proposals fall short. Specifically, they do not go far enough to address financial protections for consumers facing unexpected medical bills resulting from out-of-network providers at in-network facilities. **Therefore, the AHA recommends that CMS look to the National Association of Insurance Commissioners' (NAIC) Model Act #74, which offers the consumer greater financial protections from unexpected bills through a structured mediation process between the health plan and the out-of-network provider and apply a consistent policy both inside and outside of the marketplaces.**

ESSENTIAL COMMUNITY PROVIDERS (ECPS)

Ensuring that all ECPs are recognized is an important step in ensuring that providers serving vulnerable populations are in-network and available to consumers. CMS proposes to maintain its current approach for calculating the number of ECPs available in an area and in a QHP's network. However, it is considering changes for future years and specifically requests comments on the best approach to counting hospital ECPs for the 2019 benefit year. We remain concerned about the process for registering as an ECP. There also appears to be no oversight of whether plans are complying the contracting requirements related to ECPs. **The AHA is promoting registration within our membership, but we encourage CMS to consider alternative mechanisms to identify hospital ECPs that do not require registration. This could include using existing CMS or other Department of Health and Human Services (HHS) datasets, and conducting robust outreach to its own lists of potentially eligible hospitals**. **We also urge the agency to conduct significant oversight to ensure that plans are contracting with the minimum percentage of ECPs in their service areas.**

While not specifically addressed in this proposed rule, we also remain concerned that CMS has chosen not to disaggregate certain ECP categories to ensure better access to a wider variety of

health services. Specifically, CMS previously stated it was considering disaggregating children's hospitals and other clinics and health centers. However, the agency has now taken the position that there are not enough ECP children's hospitals in its own ECP database to provide issuers with sufficient contracting flexibility. However, we believe this conclusion is based on inaccurate data. We understand that the Children's Hospital Association will be sharing with CMS its analysis of the ECP database that found several sources of inaccuracies, such as children's hospitals that are inaccurately identified as adult hospitals. **Therefore, the AHA recommends CMS work to improve the ECP database and include the disaggregation of children's hospitals in the final rule, which will help ensure that children have access to the care they need through broader QHP provider networks.**

OTHER MARKETPLACE STABILITY MEASURES

CMS seeks input on other ways in which the agency may help stabilize the marketplaces. We recommend CMS pursue the following additional actions to improve the stability of the marketplaces, which build on input we provided in a recent letter to the HHS Secretary:

- **Fully fund the risk corridor program.** While CMS has stated that it intends to fully fund the risk corridor program, it is unclear how or when such funding and payments will be made. We encourage CMS to continue working with Congress to ensure that sufficient risk corridor funds are available and make issuers whole.

- **Extend the reinsurance program through at least 2018.** The temporary reinsurance program made $8 billion in payments in 2014 and 2015, and is anticipated to make an additional $4 billion in 2016. This program has played an important role in protecting insurers from unanticipated costs and stabilizing their participation in the marketplaces. For example, a recent report by McKinsey and Company found that the reinsurance program contributed 16 percent of provider-sponsored health plan payments for their marketplace business in aggregate.[1] While the program is set to expire at the end of this year, plans continue to face challenges in appropriate pricing for the marketplace population. We recognize that CMS has incorporated a reinsurance element into the risk-adjustment program. However, this change does not come with additional funding. We, therefore, encourage CMS to explore its options for extending the current reinsurance program through 2018 or implementing a new, but similar, reinsurance program that brings additional funding to insurers in the marketplaces.

- **Increase access to coverage through third-party payment of premiums.** While the Affordable Care Act made significant strides in making insurance less costly for consumers, some low-income Americans still cannot afford the premiums and cost sharing. As part of their charitable missions, some AHA members would like to assist these individuals by paying their portion of the premium and cost sharing, consistent with two of the "guardrails" CMS outlined in a Feb. 7, 2014 FAQ: 1) subsidies would be awarded based on financial need; and 2) the premium or cost-sharing payments would

[1] Khanna, G. et al. "The market evolution of provider-led health plans," McKinsey & Company, April 2016.

cover the entire policy year (which should be clarified to include the balance of a premium year in the event the need for financial support arises during a policy year). We, therefore, urge the agency to explicitly require QHPs to accept third-party premium and cost-sharing payments from hospitals, hospital-affiliated foundations and other charitable organizations for individuals not eligible for Medicare or Medicaid. We point CMS to our letter in response to its recent Request for Information regarding third-party payment of premiums for more detailed comments.

- **Enhance outreach and enrollment strategies.** The AHA and our member hospitals and health systems have undertaken a number of efforts to connect individuals to coverage. However, we know more work must be done. We urge the agency to dedicate greater federal resources toward both general and targeted outreach to increase the number of insured and improve the risk pool.

- **Support the development of state-level solutions.** Given statutory limitations on federal action, we encourage CMS to assist states in developing state-level solutions. For example, states may consider wrap-around risk-adjustment, reinsurance and risk corridor programs. One state, Alaska, already has authorized a state-level reinsurance program to improve the stability of its Health Insurance Marketplace. As a result, an additional insurer has opted to participate in the state's marketplace and the existing insurer has decreased its proposed rate increase for 2017. We encourage CMS to work with states to develop such solutions and to provide technical expertise, such as legal analyses of what is permissible under federal law.

- **Support state rate evaluations.** We encourage CMS to work with state regulators to promote fair and sustainable plan pricing. We understand that states' evaluation of rate proposals may be challenged by lack of consistency in how plans report financial information. Therefore, we urge CMS to work with state regulators and the NAIC to improve oversight of and consistency in plans' financial reporting, which will help states to evaluate proposed rates.

Thank you for the opportunity to provide input. Please contact me if you have questions, or feel free to have your team contact Molly Smith, senior associate director of policy, at (202) 626-4639 or mollysmith@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President