American Hospital Association

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March 2, 2020

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 2021 (CMS-9916-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 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 2021.

The AHA remains committed to ensuring that consumers have access to comprehensive, affordable coverage through the marketplaces and looks forward to continuing to work with the agency on this objective. We appreciate that most of the proposed changes in this notice are modest, which may help to support the gains in marketplace stability that have already been achieved.

Comprehensive, affordable coverage is critical to patients' access to care. We are pleased that the agency is proposing or considering a number of policies that could benefit patients by lowering drug prices and premiums, incentivizing utilization of high value services, and ensuring premium dollars are spent wisely. We are concerned, however, that CMS continues to consider changes to automatic reenrollment, which could result in the loss of coverage for vulnerable enrollees and contribute to marketplace destabilization. We also are concerned about the continued rise in annual cost-sharing limits, which many Americans already struggle to afford.

The AHA remains committed to a stable individual marketplace, with robust enrollment; this is a key component to achieving comprehensive coverage for all Americans. As

such, we encourage the agency to go further in future rulemaking to advance policies that will not only maintain the status quo but also build on the progress already made.

Such policies include substantially increasing funding for outreach and enrollment efforts, extending the open enrollment period, and increasing lower- and middle-income individuals and families' access to premium tax credits. Some of these policies have already been enacted in states nationwide, proving their effectiveness. For example, California reported a 41% increase in enrollment between 2019 and 2020 following the implementation of a new state premium subsidy and a longer open enrollment period. Closing the coverage gap is vital to the health of the individuals and communities we serve, and we look forward to working with CMS to achieve this important goal.

Our detailed comments on the proposed rule follow.

AUTOMATIC REENROLLMENT

CMS seeks comment on a new automatic reenrollment process for enrollees who do not have a premium after the application of tax credits. Under this process, enrollees would be required to actively reenroll during open enrollment or face reduced or fully discontinued subsidies. During the 2019 open enrollment period, almost 3.4 million people, or 30% of all enrollees, were automatically reenrolled in their 2018 plan (or a different plan by the same issuer) because they did not actively dis-enroll or select a new plan. As noted in the rule, in states relying on the federally facilitated marketplaces or platform, 270,000 enrollees who were automatically reenrolled were enrolled in plans without premiums after their premium tax credits were applied.

The agency is concerned that automatic re-enrollment, particularly among this population, may result in incorrect and excessive federal government spending on the premium tax credits. However, reversal of this policy is far more likely to result in eligible individuals falling out of coverage; it is therefore counter to CMS's objective of connecting as many people as possible to comprehensive coverage. In addition, this policy could have a detrimental effect on the stability of the marketplaces and drive up premiums, further putting coverage at risk and ultimately costing the federal government more in premium tax credits for those who remain.

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 achieved over the last decade is vitally important to the health of patients and communities, as well as the hospitals and health systems entrusted with their care. We urge the agency to forgo future action on this or other policies that could cause a setback to this progress.**

Instead of finalizing this policy, we again encourage the agency to provide more resources to help inform consumers about their coverage options and help them enroll. These resources are essential sources of information for individuals on how to shop for,

enroll in, and use their health care coverage. Vulnerable communities in particular need such assistance as they often have low health care literacy and are not primary targets for brokers or other private enrollment assisters. We encourage the agency to invest in a robust portfolio of navigators to provide in-person consumer assistance as part of these efforts.

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 jeopardizes patients' access to care. We refer CMS to a report released last year by AHA and the NORC at the University of Chicago that details hospital and health systems experiences with drug prices and shortages.

The AHA supports the agency's efforts to lower the price of prescription drugs, but cautions CMS to ensure that patients can maintain access to critical drug therapies, and are not at undue risk of unexpectedly high out-of-pocket costs.

Specifically, the AHA understands the agency's decision to revise the previous year's requirement permitting issuers to not apply the difference between brand and generic cost-sharing toward the annual cost-sharing limit. In its current proposal, CMS acknowledges that the previous provision raised concerns as to whether issuers are required to count the value of copay coupons toward annual limits on cost sharing when a generic option does not exist. In an effort to clarify, the agency intends to provide issuers and group health plans with the flexibility to determine whether to coupon amounts from annual cost sharing limits regardless of the availability of a generic option.

The AHA maintains that encouraging the use of generic drugs over costly brand-name alternatives, when available and medically appropriate, will allow consumers to be more involved in the decision-making process and can reduce out-of-pocket spending. When implementing this policy, the AHA expects health plans to put first patients' best interests; we are 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.

We further expect the agency will implement a robust and timely appeals process that will provide added protection for patients in need of certain drugs.

MEDICAL LOSS RATIO (MLR)

The MLR measures the amount of premium dollars that go toward health care services and quality improvement activities, and caps the amount that issuers can spend on

administrative activities or profits. CMS seeks comment on a number of proposed changes and clarifications to the MLR calculation. First, CMS proposes clarifying that issuers should report expenses outsourced to third parties consistently with how expenses are reported for directly incurred expenses. In other words, clinical service expenses performed by third parties should count towards incurred claims, whereas vendors' administrative expenses should count towards non-claims administrative expenses. CMS also proposes requiring issuers to deduct any rebates received by the issuer (or a pharmacy benefit manager contracted by the issuer) from incurred claims in the MLR calculation. Finally, CMS proposes to clarify when investments in wellness incentive programs for individual market plans qualify as "quality improvement activity expenses" for the purpose of individual market MLR calculations. While individual market issuers are currently permitted to offer wellness programs, the list of permissible wellness incentives at § 158.150(b)(2)(iv)(A)(5) only mentions group health plans. CMS proposes to clarify that individual market issuers are allowed to offer the same wellness incentives as group market issuers.

The AHA believes that the MLR standard is an important tool to ensure sufficient resources are dedicated to patients' access to care, while holding health plans accountable for how premium dollars are spent. As such, we support the proposals to clarify how third-party payments are treated and amend the treatment of prescription drug rebates in MLR calculations. We are particularly encouraged by the proposal to deduct drug rebates received by issuers or PBMs from incurred claims because, as the agency is aware, spread pricing when not properly regulated can result in health plan inefficiencies or high profit margins. By requiring drug rebate expenses to be filed as non-claims costs, the agency eliminates issuers' ability to inflate the MLR. Ensuring that incurred claims and MLRs are not inflated not only puts the patient first, but it helps to weed out plans that are unable to meet MLR requirements due to unnecessary administrative cost or excessive profits. Finally, as the agency notes, this proposal would better align the individual health insurance marketplace with current MLR requirements for Medicare Advantage and Medicaid managed care plans.

We are concerned, however, about the inclusion of wellness activities as quality improvement activities in the MLR calculations. Only those activities proven to enhance consumers' overall health should be included as quality improvement calculations. Given the broad language in the statute, issuers could abuse this policy by offering incentives without documented health benefits, such as gym memberships and fitness trackers, which are really just marketing devices. This would reduce the resources available to spend on evidence-based health care services.

VALUE-BASED INSURANCE DESIGN

In the proposed rule, CMS provides details on value-based insurance designs (VBID) that could be incorporated into qualified health plans. Such plans would aim to increase the utilization of high-value services while decreasing the utilization of low-value services through zero, reduced, or increased cost sharing. These plans would still be

subject to the standard rules regarding actuarial value and non-discrimination. To assist issuers in developing value-based health plan options, CMS includes a list of 36 high- and low-value services and drug classes based on work by the Center for Value-based Insurance Design at The University of Michigan. CMS seeks comment on these options, as well as other ways to promote and education consumers on VBID.

The AHA believes that VBID holds great potential for improving enrollee health by better targeting needed services, and we support CMS's continued efforts to test such innovations in benefit design. However, we encourage the agency to monitor the implementation of these plans to ensure that individual patients in need of certain services or drug classes that are deemed "low value" do not lose access to critical services or face additional financial barriers.

The AHA also agrees with CMS that robust consumer education will be key to ensuring that patients understand this type of benefit package as they consider enrolling in and then using a VBID health plan. Navigators are well equipped to perform this type of educational function because they assist individuals in choosing health plans during open enrollment; we encourage the agency to make significant increases to funding for these services.

MAXIMUM ANNUAL LIMIT ON COST-SHARING

CMS proposes to update the premium adjustment percentage, which would result in increased maximum annual limits on cost sharing in 2021 to $8,550 for self-only coverage and $17,100 for other than self-only coverage. **The AHA is deeply concerned that these out-of-pocket limits are unsustainable and would leave patients vulnerable to financial hardship.**

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. A recent report found that almost half of those with HDHPs through their employer report having less in savings than the amount of their deductible; two-thirds report that they would need to go into debt to afford their deductible. Similarly, the most recent Federal Reserve report on the economic well-being of US households revealed that 40% of adults would not be able to afford a $400 emergency, an amount less than 5% the proposed individual limit.

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 whether user fee rates should be reduced below the 2020 rates, which could result in lower premiums in 2021. **The AHA supports reducing the user fee rates as long as CMS and state regulators ensure that the reduction is passed on to consumers through more affordable premiums and does not compromise the functionality of the federally facilitated marketplaces or platform.** In particular, the AHA would not support a reduction in the user fees if that reduction reduced the funding available for key consumer support functions, such as eligibility and enrollment services or the consumer call center. Before making a final decision, AHA encourages CMS to ensure that any rate reductions would be the result of enhanced efficiency and not decreased funding for key components of the marketplaces.

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 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, senior associate director of policy, at (202) 626-2335 or alevin@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President