



February 19, 2019

The Honorable Alex Azar
 Secretary
 U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Washington, DC 20201

The Honorable Seema Verma
 Administrator
 Centers for Medicare & Medicaid Services
 P.O. Box 8016
 Baltimore, MD 21244

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020

Dear Secretary Azar and Administrator Verma:

Thank you for the opportunity to submit comments on the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2020 (NBPP) proposed rule. The undersigned

organizations write to express our concern over several proposals included in the proposal. We urge you to modify these proposals to better protect patients and ensure they will continue to have access to affordable and adequate health care coverage.

The 24 undersigned organizations represent millions of patients facing serious, acute, and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness, and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge the Department to make the best use of the knowledge and experience our patients and organizations offer in response to this proposed rule.

In 2017, our organizations agreed upon three overarching principles¹ to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including the services in the essential health benefit package; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care. Enrollment should be easy to understand, and benefits should be clearly defined.

Using these principles as our benchmark, our organizations are deeply concerned about many of the policies and changes included in the proposed rule and their potential impact on the communities we represent and serve. In the proposed rule, HHS put forward proposals that would increase costs for consumers on the individual market, limit the effectiveness of navigators, and promote direct enrollment practices that may confuse consumers. Based on our principles, our organizations strongly encourage HHS to modify the Notice of Benefit and Payment Parameters for 2020 (NBPP) in the final rule in the following areas:

Increasing Premiums & Out of Pocket Costs for Consumers

Premium Adjustment Formula

In the proposed rule, the Centers for Medicare and Medicaid Services (CMS) proposes changing the premium adjustment factor formula for calculating changes to subsidies, out-of-pocket caps, and other costs. While CMS previously calculated the premium adjustment factor based on employer-sponsored insurance premiums, CMS would now use average private health insurance premiums in the formula - raising the premium adjustment factor by 3.6 percent from 2019. Should this proposal be finalized as drafted, CMS anticipates that premiums for approximately 7.3 million subsidy-eligible individuals and families could increase by up to \$220², resulting in approximately 100,000 consumers losing their health insurance coverage in 2020 alone.

The proposed change to the premium measure will also result in a faster growth of the net premiums paid by consumers on the Marketplaces and a faster growth in the maximum out of pocket (MOOP) limit paid by all Americans, including those with large group employer coverage.

¹ Healthcare reform principles. American Heart Association website. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf.

² Aviva Aron-Dine and Matt Broaddus. "Change to Insurance Payment Formulas Would Raise Costs for Millions with Marketplace or Employer Plans." Center on Budget and Policy Priorities. Jan. 18, 2019, available at <https://www.cbpp.org/sites/default/files/atoms/files/1-18-19health.pdf>.

While most of the 100,000 consumers who could lose coverage are expected to remain uninsured, some may purchase short-term, limited-duration health plans (STLDHPs or short-term plans)³. STLDHPs do not meet our principles of adequate coverage and will expose consumers to medical debt, scams, and harm to both their short- and long-term health. Further, consumers who remain uninsured and underinsured will likely delay needed care, resulting in worse health outcomes and potentially increasing uncompensated care costs.

Out of Pocket Costs

We are concerned that the proposal will lead to higher costs, which will result in more Americans forgoing medically necessary services. This in turn will lead to worse health outcomes and more federal and state uncompensated care by patients accessing expensive and inefficient emergency care.⁴ Studies show that a growing number of Americans are underinsured and therefore experience difficulty paying the out-of-pocket costs associated with their care, including deductibles, copays, and coinsurance.⁵ This holds true for a cross-section of Americans (including those with large group employer coverage as well as those with individual coverage) – and it is an especially pressing concern for people with chronic health conditions.⁶ The preamble notes that the maximum out-of-pocket limit for individuals would increase by \$200 to \$8,200 for self-only coverage and by \$400 for family coverage, up to \$16,400, in 2020.⁷ These increased costs will disproportionately impact sick people that need medical services and prescriptions, including persons with chronic illnesses, and do not reflect the out-of-pocket costs paid by these groups for non-covered services.

Future Impact on Enrollment & Affordability

Finally, we are concerned about the the compounding impacts of using the alternative premium measure beyond the 2020 plan year. The changes put forward in the proposed rule, if finalized, would erode the premium tax credits, making them less impactful for low to middle income Exchange consumers. This will result in an estimated 100,000 individuals annually losing their health coverage. Further, the MOOP limit would grow at a faster rate, leaving every American with private insurance increasingly vulnerable to higher out-of-pocket costs.

We are alarmed at the hypothesis found in the preamble stating that “[e]conomic distortions may be reduced, and economic efficiency and social benefits improved, because these individuals will be bearing a larger share of the costs of their own health care consumption, potentially reducing spending on health care services that are personally only marginally valued but that imposes costs on the federal government through subsidies.”⁸ A recent study assessing consumer response to high deductible health

³ 84 Fed. Reg. at 308.

⁴ Multiple studies for the Medicaid population bear this out. See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. *J Gen Intern Med.* 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. “The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings.” Center on Budget and Policy Priorities (July 2005), available at <http://www.cbpp.org/5-31-05health2.htm>.

⁵ Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty. “Health Insurance Coverage Eight Years After the ACA.” The Commonwealth Fund. Feb. 7, 2019, available at <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>.

⁶ Drew Altman. “It’s Not Just the Uninsured – It’s Also the Cost of Health Care.” *Axios*, Aug. 20, 2018, available at <https://www.axios.com/not-just-uninsured-cost-of-health-care-cdcb4c02-0864-4e64-b745-efbe5b4b7efc.html>

⁷ 84 Fed. Reg. at 288.

⁸ 84 Fed. Reg. at 308.

plans⁹ aligns with other well-documented data showing that patients faced with high out-of-pocket costs forgo valuable care at the same rate as unnecessary care. These high out-of-pocket costs include high deductibles, high patient cost-sharing capped by the MOOP limit, payments for uncovered services, and even the full cost of health care borne by those without insurance. Therefore, while we applaud the Administration's efforts to reduce the cost of care, we urge the Administration to withdraw proposals that would increase the rates of uninsured and reduce coverage and instead to work with us to put forth options that ensure adequate coverage and improve value.

Our organizations oppose this unnecessary change to existing policy and urge the Administration to withdraw these changes to the premium adjustment formula. We also request that the Administration not take any additional actions that would further increase premium and out-of-pocket costs for consumers as such changes are likely to increase the number of people that forgo insurance or purchase inadequate coverage.

Navigators & Web Brokers

Under the Affordable Care Act (ACA), Navigators assist consumers by providing information regarding enrollment in Qualified Health Plans (QHPs) as well as post-enrollment activities, such as increasing health literacy, assisting with renewals, and educating consumers on how to avoid disenrollment for non-payment. The proposed rule would make these important post-enrollment activities optional for Navigator programs, in an effort to increase flexibility for Federally Facilitated Exchange (FFE) Navigators. FFE Navigators would also no longer have to receive training on 20 currently required training topics.

Navigators play an important role for consumers, so our organizations believe that funding and responsibilities for the program should *not* be limited, as proposed. As such we urge the Department be to restore funding for this important program and stop pursuing additional limits services. We have repeatedly communicated with the Administration about the vital role Navigators play in today's healthcare marketplace and are disheartened and concerned that the proposal further erodes their ability to assist patients and consumers to enroll in comprehensive coverage, including Medicare and Medicaid, that meets their individual medical needs.¹⁰ Our organizations strongly oppose the proposed changes to the Navigator program and urge the Administration to restore funding for this important resource.

We are also concerned that the proposed rule would allow "web brokers" to facilitate marketplace enrollment through the websites of third-party "direct enrollment entities," including issuers. While web brokers have been allowed for some time, these new proposals would shift focus away from healthcare.gov and increase the likelihood that web-brokers could recommend plans to consumers, including plans with less than adequate coverage such as short-term or association health plans, while failing to provide patients and consumers useful information needed to make informed choices. As a result of these concerns, we oppose this change and urge the administration to remove it from the final rule.

⁹ C. Brot-Goldberg, Zarek & Chandra, Amitabh & R. Handel, Benjamin & T. Kolstad, Jonathan. (2017). What does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics*. Quarterly Journal of Economics. 132. 1261-1318. 10.1093/qje/qjx013.

¹⁰See letter of July 23, 2018, from 190 patient, consumer, and provider organizations to Sec. Azar and Administrator Verma, requesting a restoration of Navigator funding. <https://www.heart.org/-/media/files/get-involved/advocacy/072318-hhs-navigator-funding-cuts-letter--final-w-signatures.pdf?la=en&hash=AE2836DAFFEF647FFC7E6E10909FE4EF7E21F478>.

Direct Enrollment

Currently, the Marketplace Exchanges rely on healthcare.gov to enroll consumers and patients into health insurance plans. Healthcare.gov has specific safeguards built into the system to help ensure patients and consumers choose a plan that is the best option for them. The Exchange also identifies patients and consumers who are eligible for Medicaid or Medicare. This is a key feature of the Exchange, allowing consumers to enroll in the most affordable and medically appropriate plan.

The Exchange also calculates a patient's advanced premium tax credit (APTC) and eligibility for a cost-sharing reduction (CSR) silver plan. These features allow patients and consumers to accurately compare the cost of the premiums between different plans and metal levels. By knowing the value of the APTC, patients and consumers can purchase the plan that is the best value for them and their healthcare needs.

In the proposed rule, HHS proposes expanding direct enrollment, which would allow insurers and web-brokers to enroll consumers in an insurance plan directly. Allowing these entities to directly enroll consumers in plans will limit the ability to compare plan price and benefit design and could ultimately result in harm to patients or consumers who become enrolled in sub-standard or inadequate insurance coverage. This failure to appropriately shield consumers from risk, particularly those with pre-existing conditions, is unacceptable. As such, we urge HHS to not finalize this provision of the proposed rule.

Changes to direct enrollment under this proposal would also not require an insurer or web-broker to list out all the plans available to a consumer shopping for health insurance. The proposed rule would only require the insurer or web-broker to link to other plans or add a disclaimer that other plans are available at healthcare.gov. Brokers frequently receive bonuses from insurers for signing consumers up for certain plans, creating an incentive for brokers to enroll individuals in plans that may not be the best option for them.

Encouraging direct enrollment will also expose patients and consumers to plans that are not qualified health plans (QHPs) during enrollment – including substandard options such as short-term and association health plans. Currently, every plan sold on the Exchange is a QHP, meaning it covers the ten essential health benefits (EHB) – including maternity care, emergency room services, and preventive services. Today, consumers can trust that they are purchasing a health insurance plan that will cover their medical needs to manage their health condition. Insurers and web-brokers selling both QHP plans and non-QHP plans may steer consumers into the less comprehensive, less expensive plans.

Non-comprehensive, skimpy health plans do not cover the services and treatments our patients need to manage their diseases and, in many cases, stay alive. Any confusion caused by obscuring the information consumers need to make informed health care decisions can result in our patients not getting the care they need. Ultimately, this can lead to poor health outcomes and increased healthcare costs for society. Our organizations strongly urge the Department to not adopt this provision in the final rule.

Essential Health Benefits (EHBs)

Our organizations continue to express our concerns regarding proposals finalized by CMS in the NBPP for 2019 that weakened EHBs. Last year, the Administration moved to destabilize these core patient protections by allowing states to mix and match benefit structures in a way that could harm patients.

We strongly urge the Department not to encourage states to weaken their EHB benchmarks. Only one state, Illinois, chose to utilize these new options by including alternative therapies for chronic pain and

expanding coverage to opioid and substance use disorder treatment, which we view as a positive use of the flexibility granted by CMS. However, we remain concerned that other states may choose to design new EHB-benchmark plans that offer less generous coverage and would not provide adequate benefits for our patients.

We are also concerned that the flexibility allowed under this policy, combined with other administrative actions finalized by the Administration, such as the expansion of AHPs and short-term plans and new guidance on 1332 waivers, could allow states to degrade patient protections and give them authority to offer not just less generous coverage but the *least* generous coverage – jeopardizing the integrity of the ACA and the policies that underpin its quality.

Special Enrollment Periods

Special enrollment periods (SEPs) provide an important opportunity to enroll in coverage when consumers' circumstances change during the course of the year. We support HHS' proposal to establish a special enrollment period for individuals with "off-Exchange" coverage who experience mid-year income changes, to facilitate consumer access to more affordable Marketplace plans when they become eligible for advance payments of the premium tax credits.

Given that this SEP may be implemented at the discretion of state-based marketplaces, we strongly encourage HHS to consider *requiring* state-based Exchanges to establish an SEP for individuals with off-Exchange coverage who experience mid-year income reductions as well.

Risk Adjustment

The permanent risk adjustment program plays an integral role in promoting insurance quality by minimizing risk selection and encouraging insurers to develop insurance products that are competitive on price and value. An accurate and effective risk adjustment program is essential in preventing discriminatory insurance benefit designs and protecting access to care for patients with chronic, acute, and life-threatening diseases.

Given the importance of the permanent risk adjustment program in protecting consumers and transferring billions of dollars among participating plans, we support HHS' proposal to improve the program's methodology by adding prescription drugs into error estimations. Prescription drugs are an essential and often costly treatment for many conditions, and the newly-proposed risk adjustment program methodology should prevent plans from designing benefit packages to select against patients who rely on prescription therapies. In addition, we support HHS' proposal to release data related to the risk adjustment program for use by research and public health purposes. A program as important as risk adjustment will benefit from the opportunity for external accountability that comes with providing researchers outside the government with this data.

Request for Information

The Department has requested information on various policy proposals for future rule makings. Our organizations have provided feedback on these proposals below. We judged these proposals on the potential impact they will have on improving the affordability, accessibility and adequacy of health insurance for all patients, especially those with pre-existing conditions:

Silver Loading

In October of 2017, the Administration, per advice from the Attorney General, stopped funding the cost-sharing reduction payments (CSRs) that section 1402 of the ACA requires insurance companies provide to low-income marketplace enrollees. As issuers were still required to provide the subsidies to low-

income enrollees but no longer received federal funding to pay for them, they increased premiums to cover their costs. The practice of silver loading refers to increasing premiums only for on-Exchange silver plans to cover the cost of CSRs, as opposed to spreading the cost over all individual market plans.

An unexpected but beneficial result of silver loading for consumers has been an increase in the value of advanced premium tax credits (APTC), since the government calculates APTCs using the cost of the second-lowest cost marketplace silver plan. This has made it possible for some consumers to pay less for bronze or gold plans than they would have in years past. Silver loading has also kept premiums of bronze, gold, and platinum level plans more affordable than they would have been absent the practice, giving unsubsidized consumers more affordable alternatives.

It is important that the Department allow silver loading to continue until such time as a broader solution on CSR payments, stabilization, and marketplace affordability is reached and current attempts to administratively undermine the ACA cease. Absent silver loading, premiums for all individual market plans will rise and the value of APTCs will fall, exacerbating affordability issues for unsubsidized and subsidized consumers alike and reducing marketplace enrollment.¹¹ Our organizations have supported marketplace stabilization efforts in the last Congress and will continue to call for renewed efforts on this topic, evaluating any proposal on its potential to improve the affordability, accessibility and adequacy of health insurance for all Americans.

Until there is a permanent solution regarding the CSR payments and the overarching affordability of insurance premiums, our organizations urge the Department to allow silver loading. Our organizations believe that by staying consistent and keeping silver loading, the market will be more stable, which will be reflected in premiums. A stable market and insurance premiums that reflect market stability are important for patients, especially those with pre-existing health conditions. Patients need to be able to plan healthcare costs more than 12 months into the future. Many of our patients will need treatment for the rest of their lives – it is important that they can plan for their future.

Once permanent and stable CSR funding is secured, silver loading will no longer be needed to offset the lack of CSR funding. For some patients this could result in increased out-of-pocket costs for premiums as a result of the less generous APTCs. *When and only when* there is permanent and stable CRS funding, our organizations encourage the Department to phase out silver loading to lessen the financial impact on patients and keep stability in the marketplace.

Our organizations do acknowledge that some consumers are negatively impacted by silver loading, specifically those individuals and families that have incomes over 400 percent of the federal poverty level. With the increased premiums of silver plans, they may have fewer affordable options. Our organizations continue to encourage Congress and the Administration to work together to reduce premiums and stabilize the market for all enrollees.

Auto Renewal

The Department seeks comment on possibly changing the process for automatically re-enrolling consumers in health insurance plans offered through an FFE or State-Based Exchange (SBE). Currently, consumers are automatically re-enrolled in their current plan if they do not take active action to change

¹¹ Anderson D. et al. Implications of CMS Mandating A Broad Load Of CSR Costs. <https://www.healthaffairs.org/doi/10.1377/hblog20180511.621080/full/>. Accessed February 7, 2019.

their plan. In 2018, approximately 25 percent of consumers were automatically renewed in their plan;¹² a total of 1.8 million were re-enrolled for plan year 2019. Our organizations are concerned that, if removed, automatic re-enrollment would leave significant numbers of people uninsured or with gaps in coverage. This would be a particular concern among older adults, people with low health literacy, and people at low-income levels. Given the lack of a compelling reason to change the policy, we urge CMS to retain auto-renewal in its current form.

Conclusion

Our organizations represent millions of patients who need access to quality and affordable healthcare regardless of their income or geographic location. We appreciate the opportunity to provide observations, analyses and recommendations on the proposed rule. However, we would like to reiterate our concern that the cumulative impact of the 2020 NBPP proposed rule could seriously undermine the key principles of access, adequacy, and affordability that are the underpinnings of current law.

As leaders in the health care and research communities and staunch patient advocates, we look forward to working closely with HHS leadership and staff on the direction of such important public policy. Thank you for the opportunity to submit comments on this important rule. If you have any questions, please contact Katie Berge, AHA Government Relations Manager, at katie.berge@heart.org or 202-785-7909.

Sincerely,

Adult Congenital Heart Association
American Cancer Society Cancer Action Network
American Heart Association
American Liver Foundation
American Lung Association
Arthritis Foundation
Chronic Disease Coalition
Crohn's & Colitis Foundation
Epilepsy Association
Family Voices
Global Healthy Living Foundation
Hemophilia Federation of America

Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes
Muscular Dystrophy Association
National Alliance on Mental Illness
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization of Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
United Ostomy Association of America, Inc.
WomenHeart: National Association for Women with Heart Disease

¹² Armour S. Trump's Proposed ACA Rules Could Boost Costs for Millions of People. The Wall Street Journal. 2019. Available at https://www.wsj.com/articles/trumps-proposed-aca-rules-could-lift-costs-for-millions-of-people-11547775475?emailToken=774bc4bebc0f134eb1cbdb62929ce275slrMAjxYosOIBrHI2PV0GhknF/RER9kfvVE2/R4Uup5GtaR04vGLsQ+2sU34h6a/7caWwpP7v/ncdNJP4A8I8U8HSz7rRRnF/utKpV9ZDyiA8Uuvgt0Dvn3OvxPwA8JL&reflink=article_email_share.