



Charles N. Kahn III
President and CEO

March 2, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; 85 Fed. Reg. 25 (Feb. 6, 2020); CMS-9916-P

Dear Administrator Verma:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care across settings in both urban and rural areas. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals. They provide a wide range of acute, post-acute, emergency, children's, cancer care, and ambulatory services. The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding its proposed rule, on *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021* (Proposed Rule).

D. Part 155 – Exchange Establishment Standards and Other Related Standards

Automatic Re-Enrollment Process

The FAH is very concerned about CMS' proposal to modify the re-enrollment process so that any enrollee who, under existing rules, would be automatically re-enrolled in their plan with an advanced premium tax credit (APTC) covering the entire premium would instead be automatically re-enrolled without any APTC or with a reduced APTC. **We urge CMS not to finalize the proposal. Rather, the FAH strongly urges CMS to continue the successful re-**

enrollment processes that have been in place since 2014 because any changes to the program would be unnecessarily confusing¹ and destabilizing, and could increase premiums and jeopardize coverage levels. As CMS notes, automatic re-enrollment is consistent with broader industry practices and provides key benefits, including lower administrative costs and increased consumer convenience. Furthermore, as commenters have previously noted, automatic re-enrollment helps to stabilize the risk pool due to the retention of lower-risk enrollees who are least likely to actively re-enroll, increases efficiencies and reduces administrative costs for issuers, reduces the numbers of uninsured, and lowers premiums. Recognizing the significant value of automatic re-enrollment, Congress recently amended section 1311(c) of the Affordable Care Act (ACA) to mandate automatic re-enrollment for plan year 2021.² Automatic re-enrollment has, since the inception of the program, included redeterminations of individuals' eligibility for advance payment of the premium tax credit.

CMS, however, proposes significantly changing the automatic re-enrollment process such that the approximately 270,000 individuals with income levels that qualify them for APTCs that fully offset plan premiums would be automatically re-enrolled *without* an APTC or, in an alternative proposal, at an APTC level that does not fully offset plan premiums.³ This would be undertaken even in cases where periodic data matching and other processes indicate that the taxpayer continues to be eligible for APTCs that fully cover his or her premiums. At present, CMS, the Exchanges, and the Internal Revenue Service (IRS) have critical programs in place designed to ensure that APTC amounts are appropriate based on the statutory eligibility criteria set forth in section 1411 of the ACA.⁴ These safeguards include, but are not limited to, eligibility redeterminations, electronic and document-based verification of eligibility information, periodic data matching, and premium tax credit reconciliations. CMS recently expanded on these safeguards in the Exchange Program Integrity final rule, which ensures that periodic data matching occurs at least twice each calendar year beginning in 2021 so that enrollees receive the correct amount of APTCs.⁵

In the Proposed Rule, CMS fails to identify any data indicating that current safeguards do not sufficiently ensure the accuracy of APTC expenditures. Nor does CMS identify any other basis for its concern that error rates for APTC expenditures exceed acceptable bounds with respect to individuals who are automatically re-enrolled and are entitled to APTCs that fully cover premium costs. Rather, it appears that the concern arises from Congress' statutory mandate

¹ The proposal would cause mass confusion for affected Exchange enrollees, causing them unnecessarily to lose coverage. In fact, there is a history of problematic federal Exchange communications to enrollees regarding re-enrollment. In 2015, the GAO found that federal Exchange communications were not clear and complete and that guidance about the documents needed for re-enrollment were sometime inaccurate. To the extent that Exchange communications are confusing or incorrect, they may be causing the number of individuals who do not actively renew their enrollment to rise.

² Further Consolidated Appropriations Act, 2020, Pub. L. 116-94, § 608 (Dec. 20, 2019) (amending section 1311(c) of the ACA, 42 U.S.C. § 18031(c)).

³ 85 Fed. Reg. at 7,119.

⁴ 42 U.S.C. § 18081.

⁵ 84 Fed. Reg. 71,674 (Dec. 27, 2019). *See also* 45 C.F.R. § 155.330(d).

limiting APTC reconciliation recoveries for those of modest means.⁶ It is inappropriate to use Congress' decision to statutorily protect taxpayers of modest means from excessive obligations during APTC reconciliation to deprive such individuals of an APTC at the most appropriate level based on available information.

Moreover, the proposal to reduce or eliminate APTCs for certain individuals who are automatically re-enrolled is inconsistent with section 1412 of the ACA, which governs the procedures for determining APTC eligibility.⁷ Under section 1412(b)(1)(B), APTC determinations are to be made "on the basis of the individual's household income for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines information is available."⁸ The ACA does not permit the Exchanges to consider information unrelated to APTC eligibility in making APTC determinations. Thus, CMS cannot require that Exchanges reduce or eliminate APTCs based on whether an individual is undergoing automatic re-enrollment. Given the requirements of section 1412, when Congress mandated automatic re-enrollment for plan year 2021, it certainly could not have intended for CMS to propose to automatically re-enroll qualified individuals without any APTC or with a reduced APTC. **Because the proposal runs contrary to Congress' statutory direction concerning APTC determinations, would have a destabilizing effect, and is not based on any rational justification, the FAH strongly urges CMS to decline to finalize any policy eliminating or reducing APTCs for individuals that are automatically re-enrolled in coverage through an Exchange.**

Special Enrollment Periods

The FAH is strongly committed to ensuring stable health insurance Exchanges and recognizes that their success relies on the ability of Americans to avail themselves of Exchange coverage, and most importantly, to receive needed health care services. **As such, we support CMS' efforts to propose changes to Special Enrollment Period (SEP) policy intended to fill-in where existing policies leave gaps in access to health coverage.**

CMS proposes to establish a SEP for enrollees who become ineligible for cost-sharing subsidies to enroll in a non-silver metal-level plan; to require Exchanges to allow an individual who qualifies for a SEP to join a plan covering one or more of their dependents who are already enrolled in a Qualified Health Plan (QHP); and to permit greater flexibility on the starting dates for prospective and retrospective coverage.

The FAH supports these efforts to fill gaps in SEPs and to make start dates for coverage more flexible. **We also, however, encourage CMS to ensure that the new flexibilities and SEPs are implemented in a manner that mitigates any unintended effects.** In particular,

⁶ 85 Fed. Reg. at 7,119; *see also* Internal Revenue Code § 36B(f) (26 U.S.C. § 36B(f)) (limiting reconciliation for households with income less than 400% of the federal poverty level).

⁷ 42 U.S.C. § 18082.

⁸ 42 U.S.C. § 18082(b)(1)(B). An exception is available for cases where an individual's application demonstrates significant changes affecting eligibility (*e.g.*, substantial changes in income and changes in family size).

CMS should ensure that special enrollment processes and related communications are not overly burdensome or complicated. We encourage CMS to prioritize an automated, consumer-friendly process that encourages compliance through ease of use. Further, CMS discusses that SEP retroactive coverage effective dates when a special enrollment verification is prolonged are no longer needed since delays in the verification process are rare. We encourage CMS to monitor these circumstances and ensure that prolonged verification processes continue to be rare.

While we support the proposed changes to SEPs, we also encourage CMS to take actions to increase enrollment during regular open enrollment periods. CMS should target enrollment efforts to address the reasons that those consumers did not enroll during the regular open enrollment periods. Strengthening the individual market risk pool through regular enrollment and keeping those individuals enrolled throughout the year will help blunt the harder-to-anticipate risk that the market may experience if large numbers of individuals are enrolling in coverage during a SEP rather than during regular open enrollment.

Data Matching Provisions

CMS proposes changes to the rules for terminating coverage when periodic data matching identifies that a person is enrolled in other qualifying coverage or that an enrollee has died. Certain conditions would need to be met in order for Exchanges to terminate coverage without the need for a redetermination based on the results of data matching results. For example, to terminate the coverage of a person found to be dually enrolled in other qualifying coverage, the person must not have responded to an Exchange inquiry for updated information within 30 days and have provided advance written consent to the Exchange to terminate their coverage based on periodic data matching.

The FAH urges CMS to carefully monitor implementation of these proposals to ensure that they do not inaccurately result in gaps in coverage for people based on periodic data matching errors. We believe caution is essential. CMS does not provide data on the accuracy of existing periodic data matching and we are not aware of any such data. If CMS were to detect that people who remain eligible for their Exchange coverage were being terminated in error because of these policies, CMS should be prepared to immediately reverse the policies rather than continue to enable Exchanges to terminate coverage for individuals who may continue to be eligible.

E. Part 156 – Health Insurance Issuer Standards under the ACA, Including Standards Related to Exchanges

Premium Adjustment Percentage

The premium adjustment percentage is used to calculate the maximum annual limitation on cost-sharing, the required contribution percentage for individuals for minimum essential coverage, and the employer mandate. It also impacts the amount of federal premium tax credits. It is an important calculation as it impacts the affordability of health coverage for millions of Americans.

Under the Proposed Rule, CMS proposes to follow the same methodology as used for 2020 – in which it incorporates the growth of individual market premiums into the calculation of the premium adjustment percentage. This is in contrast to the calculation for prior years in which the growth factor was based only on the growth of premiums in the employer market. CMS made this change last year arguing that premiums in the individual market have stabilized sufficiently that inclusion of the individual market premiums in the calculation is warranted.

We opposed this methodology change last year and continue to do so. Incorporating the growth of individual market premiums negatively impacts consumers compared to calculating the premium adjustment percentage only with the growth of premiums in the employer-based market. It raises the annual limit on beneficiary cost-sharing, increases a consumer's minimum premium contribution amount, and decreases the value of the premium tax credit. Last year, CMS estimated that the methodology change would increase the number of people without insurance by approximately 100,000. We would expect similar drops in coverage because of this approach.

Given that CMS' proposal would increase the number of uninsured and raise costs for those who remain in the individual market, we urge CMS not to finalize its proposal to calculate the premium adjustment percentage by incorporating individual market premium growth.

Requirements for Timely Submission of Enrollment Reconciliation Data

The FAH supports CMS' proposal to establish standards for the existing monthly enrollment reconciliation process between plans and Exchanges. Under existing rules and guidance, federally facilitated exchanges (FfEs) are required to reconcile enrollment records with all participating issuers on a monthly basis. Reconciliation is intended to ensure that QHP issuers and the Exchanges have the same enrollment information so that CMS can make correct payments for APTCs, and correctly assess FFE user fees. The proposed standards would require that issuers submit, in their enrollment reconciliation submission, the most recent enrollment information that is available and is verified and update those submissions for errors and notify the Exchange of the errors within 30 days.

Providers rely on the accuracy of issuer's enrollment information. Enrollees also need to be assured that their enrollment is accurate and their premium subsidies are correct. Uncertainty and mistakes negatively impact enrollees and providers. Requirements that plans rapidly address enrollment data errors would be beneficial for the stability of coverage in the individual market and the experience of enrollees and providers who participate in plans in that market.

Promoting Value-Based Insurance Design

In describing a proposal to promote value-based insurance design (VBID) and assist QHP issuers with designing value-based plans, CMS notes that it sought comments in the 2017, 2018, and 2019 Payment Notices. Commenters were asked about how to encourage VBID within the individual and small group markets. In the Proposed Rule for 2021, CMS provides a proposal, presumably based on the feedback that it received over those years, comprised of a table that lists

high value services and drugs and low value services – or those services “in which the majority of consumers would not derive a clinical benefit.”

In addition, the table includes a list of “commonly overused service categories with increased cost-sharing.” Items such as outpatient specialist services, outpatient labs, x-rays, other types of diagnostic imaging, and outpatient surgical services appear on that list.

We are very concerned that the table that CMS provides seems to describe the extent of the proposal. In that sense, we believe this proposal is undeveloped and unclear. It is unclear exactly what CMS means to convey by the listed items, drugs and services, and there is no indication of how a VBID plan would distinguish between when these items are medically necessary versus unnecessary. The list of commonly overused service categories with increased cost sharing is perplexing: it includes items and services that can be essential in certain circumstances for certain patients and unneeded under other circumstances for other patients.

Further, the language in the preamble is unclear as to whether CMS is exploring this policy for the future or if CMS intends to promote VBID QHPs for the 2021 or 2022 plan years. Finally, the language does not address complicated questions about medical necessity, the interaction of VBID plan design with prior authorization, and quality care – one of the hallmarks of the “value” component of VBID – is not mentioned at all. Thus, it is difficult to provide thorough comments on the proposal.

While we support seeking better value in health insurance plans and promoting designs that provide high-quality and high-value care, we urge CMS to provide a more carefully well-developed value-based policy that ensures appropriate incentives for high quality care. A table that lists services and drugs is insufficient and does not rise to the level of a proposal to promote value-based design.

F. Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirements

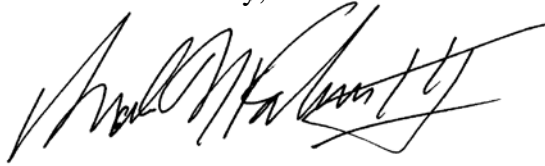
Medical Loss Ratio Proposals

FAH supports CMS’ proposal to require issuers to report prescription drug rebates and price concessions as non-claims costs in calculating a plan’s medical loss ratio (MLR). We agree that ensuring that these discounts are not incorporated as offsets to claims costs in the numerator of the ratio will increase the likelihood that enrollees receive the benefit of prescription drug rebates and price concessions, and will help ensure that the MLR correctly captures the extent to which issuers devote premium revenue to the actual cost of medical care.

While we appreciate that this proposal could help beneficiaries to experience some of the benefit of negotiated rebates and price concessions, we urge CMS to continue to work toward addressing the high cost of prescription drugs at the manufacturer level.

The FAH appreciates the opportunity to comment on the Proposed Rule. We look forward to continued partnership with the CMS as we strive for a continuously improving health care system and individual market Exchanges. If you have any questions regarding our comments, please do not hesitate to contact me or a member of my staff at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Reinhart". The signature is fluid and cursive, with a large initial "A" and "M".