Federation of American Hospitals®

Charles N. Kahn III
President and CEO

December 21, 2018

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

SUBJECT: Request for Comments on CMS-9936-NC; State Relief and Empowerment Waivers

Dear Administrator Verma,

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. We appreciate the opportunity to submit comments on the October 24, 2018 Notice providing guidance relating to section 1332 of the Affordable Care Act (ACA) and the November 29th discussion paper "Section 1332 State Relief and Empowerment Waiver Concepts."

Section 1332 permits states to have applications approved for state plans that waive specific provisions of the ACA to implement alternative state programs. Under an approved waiver, states can receive "pass-through" payments comprising the amounts that would have been spent on premium tax credits, small business tax credits and cost-sharing reductions in the state. To receive approval for a waiver under section 1332, the state's proposal must meet certain statutory "guardrails" intended to protect state residents and the federal budget and to ensure state programs are at least as generous as the programs under the ACA provisions.

The four statutory guardrails require states' plans to:

(1) Provide coverage that is at least as comprehensive as coverage defined in ACA section 1302(b) and offered through Exchanges. Section 1302(b) describes "essential health benefits."

(2) Provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided under title I of ACA (its coverage provisions);
(3) Provide coverage to at least a comparable number of the state's residents as would be provided under the coverage provisions of the ACA; and
(4) Not increase the federal deficit.

The October guidance issued by the Department of Health and Human Services and the Department of the Treasury ("the Departments") loosens the application of those standards so that states can more easily receive approval for implementing what the Departments call "State Relief and Empowerment Waivers." The discussion paper provides four examples of waiver "concepts" that could potentially be approved under the new guidance.

The FAH recognizes and supports state flexibility and innovation and therefore we support the general objective of section 1332 of the ACA. We also believe the Departments have an obligation to ensure that the statutory guardrails are met and that individuals seeking coverage in those markets are protected. ***Unfortunately, the revisions described in the October notice are incongruent with the statute and as such, we oppose them.***

Changes to Interpretation of Guardrails

The Departments describe several new interpretations that it will apply in determining if a state waiver application meets the statutory guardrails:

- Guardrails relating to comprehensiveness of coverage and affordability will no longer be based on the comprehensiveness or affordability of actual coverage that individuals have, but rather based on the comprehensiveness or affordability of coverage that is available to them.
- The Departments will no longer require states' plans to provide for coverage that is as comprehensive and affordable to a *comparable number* of state residents as under the ACA.
- In applying the coverage guardrail, the Departments will allow state waivers that cover "health insurance coverage" -- a term that the Departments interpret as including plans that do not provide minimum essential coverage.[1]

Taken together, the new interpretations will likely allow states to receive approval for plans that provide access to, and use federal funds to pay for, less comprehensive coverage than required under the ACA. Under the guidance, states could do this so long as the option to purchase more comprehensive coverage remains available to at least some individuals.

Indeed, the discussion paper provides, in Waiver concept B, that state plans can use pass-through funding to subsidize coverage that does not qualify as a QHP – including short-term/limited duration plans, catastrophic plans, plans that do not meet EHB requirements, and condition-specific benefit plans.

These revised interpretations of statutory guardrails and CMS's waiver concepts raise considerable concerns. They are not consistent with either the spirit or the meaning of the law

[1] Minimum essential coverage is defined in 26 U.S. Code 5000A and generally means coverage of at least 60% actuarial value.

and, based on the choices enumerated in the discussion paper, appear to be intended to encourage more enrollment in plans that do not cover a minimum set of essential benefits despite a statutory guardrail that is specifically intended to protect access to such benefits. We believe that this guidance, if acted on by states, will do great harm to the individual market, undermining its overall stability.

Less Comprehensive Coverage

Under the guidance and as described in the discussion paper, states could make federal subsidies available for plans that are not subject to the minimum benefit standards that apply to ACA-compliant benefit plans. The guidance indicates that states could offer short-term, limited duration coverage or other bare bones benefit plans meant to attract only the healthiest of individuals. Given the benefit design of these types of plans, this means federal subsidies could be used for plans that exclude coverage for prescription drugs, avoid covering maternity care, cancer care, or certain services for mental illness, for example.

Over time, only those with the highest health needs and expenses would remain in comprehensive plans and the cost of that coverage is likely to escalate. Coverage of hospital services could be greatly compromised, thus leading to increasing underinsured and rising hospital bad debt. This outcome explicitly undercuts the critical public health goals that were embodied in ACA overall, and in the statutory guardrails intended to guide the approval of waivers.

Increasing Instability in the Individual Market

This guidance would also introduce instability based on the ability of certain plans to "cherry-pick" through the design of covered benefits and put the stability of the individual market at risk. As is likely to occur under the new guidance, individuals with costly health care needs or conditions will become concentrated in comprehensive ACA-compliant health plans while other healthier individuals or those with lower health care costs choose more limited benefits offerings through non-compliant plans.

As is well-documented, medical expenses are concentrated in a small percentage of the population. Insurers in a state that provides incentives for limited benefit plans that compete with more comprehensive benefit plans can be expected to take every opportunity to avoid bad risk. By providing states with incentives to establish this clash of incentives, comprehensive plans will absorb a greater share of higher-cost patients, threatening that market's basic stability.

The FAH recognizes the need to maintain affordability in the individual market for health insurance. Indeed, with over 80% of all individuals purchasing coverage through exchanges eligible for tax credits to help pay that coverage and a number of states developing reinsurance programs under prior existing 1332 guidance, we believe that there is no need to implement policies that would discourage comprehensive benefit packages, especially when those policies introduce instabilities that could ultimately undermine the continued ability of insurers to offer affordable, comprehensive coverage options.[2] ***Given this, the FAH reiterates our opposition to the new guidance.***

[2] See https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2018-open-enrollment-period-final-report.

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The FAH appreciates the opportunity to comment on this guidance. If you have any questions regarding our comments, please do not hesitate to contact me or Paul Kidwell of the FAH staff at (202) 624-1500.

Sincerely,