



Charles N. Kahn III  
President and CEO

February 19, 2019

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 2020; 84 Fed. Reg. 227 (Jan. 24, 2019); CMS-9926-P***

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, short-stay acute, inpatient rehabilitation, long-term acute care, psychiatric and cancer hospitals in urban and rural America, and provide a wide range of acute, post-acute 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 2020* (Proposed Rule).

*E. Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act*

The FAH supports clarifying and refining the definitions (Section 155.20) of “direct enrollment technology provider”, “direct enrollment entity”, “direct enrollment entity application assister”, and “web-broker.” As new channels are developed for consumers to evaluate their exchange options and enroll on the exchange, the FAH continues to encourage CMS to refine its oversight over those who assist and influence consumers with their exchange selections. To this end, the FAH would continue to encourage CMS to collect information on incentives provided to persons or entities that influence consumer choices so CMS may evaluate the extent, if any, those incentives do influence consumer choice.

Direct Enrollment Entities Display of Qualified Health Plan (QHP) Information  
(Sections 155.220 and 155.221)

The FAH supports CMS in its efforts to require direct enrollment entities to clearly distinguish QHP products from non-QHP products with exchange consumers. In its proposal, CMS states under certain circumstances, “the direct enrollment entity could begin marketing and displaying the non-QHP health plans and/or off-Exchange products after the consumer completes the Exchange eligibility application and QHP selection process.” The FAH is concerned that consumers that complete this process and then begin reviewing non-QHP plans or off-Exchange plans will be considering coverage alternatives to the more comprehensive QHP coverage that is inadequate or inappropriate for their particular situation and may inappropriately consider a non-QHP alternative as a substitute for QHP coverage when in fact, it may offer fewer benefits or include coverage restrictions. The FAH suggests that more protection should be afforded the consumer and more scrutiny applied to the direct enrollment entity sales process where the consumer is being sold coverage which potentially could be seen as substitute coverage for QHP coverage.

HHS Proposal to Strengthen Oversight, Audit, and Compliance Mechanisms for  
Direct Enrollment Entities (Sections 15.221(d) and (f)).

As direct enrollment of consumers for the Exchanges expands, the FAH supports CMS use of additional reporting requirements and enforcement tools with direct enrollment entities to protect consumers from fraudulent activities and from misuse of their personal information.

*F. Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act,  
Including Standards Related to Exchanges*

Silver Loading

We appreciate CMS’s indication that it supports a legislative solution to ensure cost-sharing reduction (CSR) payments are again made available. Since 2017, the FAH has encouraged both the Administration and Congress to ensure the availability of these payments as they are important to ensuring the stability of the individual market and affordability of coverage for individuals. We regret that these payments are not currently available and encourage the Administration and Congress to work together to find a solution.

In the meantime, we are pleased that states have adopted silver-loading as a way to protect tax credit eligible individuals from premium increases associated with the lack of CSR payments. Short of CSR payments resuming, we urge CMS to preserve the practice of silver-loading in order to protect the affordability of coverage offered on the 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 seeks to incorporate in the calculation of the premium adjustment percentage, the growth of individual market premiums instead of only including the growth of premiums in the employer market, as CMS has done in the past. CMS argues that premiums in the individual market have stabilized sufficiently that inclusion of the individual market premiums in the calculation is warranted.

Unfortunately, CMS's proposal would create a number of negative impacts for consumers. It will raise the annual limit on beneficiary cost-sharing, will increase a consumer's minimum premium contribution amount, and decrease the value of the premium tax credit. CMS estimates that approximately 100,000 individuals would leave the Exchanges with most of those individuals become uninsured.

Given CMS's proposal would result in increasing the number of uninsured and raising costs for those that remain in the individual market, we request that CMS not finalize its proposed change to the premium adjustment percentage.

#### *Automatic Re-enrollment*

The FAH urges CMS to exercise caution in implementing any changes for the 2021 plan year that would discourage auto-reenrollment on the Exchanges. It is unclear from the data to date whether consumers who are auto-reenrolled in Exchanges year to year are less aware of their options from year to year. In a November 2017 report, the Government Accountability Office (GAO) reported that 70 percent of consumers (3.9 million) in the 2015 federal exchanges actively re-enrolled in 2016.<sup>1</sup> While 70 percent actively re-enrolled, only 30 percent were automatically re-enrolled.<sup>2</sup> While there is data to show Exchange consumers (70 percent in 2016) have taken an active role in re-enrollment, there is very little data on what factors have motivated consumers to take an active role in re-enrollment versus a passive role (automatic re-enrollment) and whether those choices have led to more eligibility errors, tax credit miscalculations, and unrecoverable federal spending.

We believe more analysis should be considered before finding auto-reenrolled consumers are shielded from coverage changes and their coverage options from year to year. Consumers on the Exchange are not significantly different from consumers in employer-based plans or plans provided through Medicare or Medicaid, all of which provide premium subsidies which insulate beneficiaries, to different degrees, from the impact of coverage choices. Despite the subsidy, current data does not reveal whether auto-reenrollment is a conscious choice of consumers based on their own circumstances or a choice made with little consideration of changed circumstances. The FAH would recommend further inquiry into whether limitations on auto-reenrollment would lead to tangible improvements in federal spending or benefits to consumers on the Exchange.

#### *High Deductible Health Plans and Health Savings Accounts*

We are concerned with the preference expressed in the proposal for High Deductible Health Plans (HDHPs) that can be paired with Health Savings Accounts (HSAs). In the proposed rule, CMS expresses interest in how these types of plans can be highlighted as a choice on the Exchanges.

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<sup>1</sup> GAO-18-68 Health Insurance Exchanges, p. 19 (Nov. 2017)

<sup>2</sup> Ibid

It is important that consumers have a choice of a variety of comprehensive plans when they are selecting coverage for purchase in the Exchanges. While HDHPs paired with a HSA may be attractive to some, it is imperative that consumers understand the high out-of-pocket costs associated with such plans. While the potentially lower premiums for these plans may be attractive, without proper funding of a HSA or other means to account for high out-of-pocket expenses, consumers are likely to be surprised and potentially unable to manage their portion of the financial responsibility for their care. We encourage CMS to consider the potential negative impact on consumers if such plans are highlighted over other more comprehensive plans or if these plans are not accompanied by information addressing the high out-of-pocket-costs for which a consumer would be responsible.

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Thank you for the opportunity to comment on the proposal. Should you have any questions please feel free to contact me or Paul Kidwell at the FAH at (202) 624-1500.

Sincerely,

A handwritten signature in black ink, appearing to read "Paul Kidwell", written in a cursive style.