



Charles N. Kahn III  
President and CEO

December 22, 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 2022 [CMS-9914-P]***

Dear Administrator Verma:

The 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 in both urban and rural America. Our members include teaching and non-teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer 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 2022* (proposed rule) published in the Federal Register (85 Fed. Reg. 78572) on December 4, 2020.

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

Exchange Direct Enrollment

CMS proposes to allow states to opt into an Exchange Direct Enrollment (EDE) option where states could replace their single, centralized health insurance Exchange with enrollment through private insurers, web-brokers, and agents and brokers. Consumers would shop for plans, select and enroll in coverage through those private entities.

CMS expects that by replacing centralized Exchanges with the individual websites of insurers, agents, and brokers, market forces will arise, providing for lower costs and greater customization of the enrollee's experience. The FAH is concerned with CMS' proposal to replace a one-stop shopping experience for consumers through a financially disinterested party (the state Exchange) with enrollment through parties that have a financial interest in securing a person's enrollment into certain plans. We are also concerned that CMS' proposed safeguards will not appropriately mitigate these conflicts of interest and lack of transparency.

Specifically, we are concerned that EDE vendors do not have to display all Exchange offerings, rather they *may* display them, and they may not identify market plans that do not cover Affordable Care Act (ACA) essential health benefits such as short-term limited duration plans. In addition, we are concerned that EDE vendors are unable to determine if a person enrolling through their website may be available for free or lower-cost Medicaid or Children's Health Insurance Program (CHIP) coverage. Further, the incentive for issuers to compete on price because consumers could easily compare alternative plan choices displayed on the Exchange website will no longer exist. The loss of these advantages and functionality for consumers when compared with enrollment through Exchanges could result in a loss of enrollment into plans best suited for enrollees, a loss of coverage for the types of services and benefits that individuals need most, and higher priced health plans.

An examination of EDE vendors in 2019 found that many of those concerns are in fact, reality. Some EDE vendors redirected enrollees to non-ACA compliant plans, ignored a consumer's likely eligibility for Medicaid or CHIP, or steered enrollees into higher commission products.<sup>1</sup> While the FAH supports efforts to enhance the ability and ease with which qualified individuals gain coverage, the FAH urges CMS not to finalize the proposals at this time.

Should CMS proceed with finalizing the alternative to Exchange enrollment, at a minimum, states and CMS must increase their oversight of EDE vendors. Careful state and CMS oversight of EDE vendors and their practices is necessary to ensure that EDE will not result in a loss of coverage or an escalation of high cost, reduced benefit plans. Such oversight should ensure that EDEs do not misrepresent non-ACA compliant coverage, misrepresent a consumer's choices, or present those options in a confusing way. Adequate oversight must also ensure that automatic re-enrollment requirements are met, even when an EDE issuer no longer offers an enrollee's plan.

The FAH encourages CMS to monitor plan selection and enrollment patterns of individuals using EDE and compare with individuals choosing plans through traditional Exchanges. This will allow CMS to better evaluate how the use of EDE impacts plan selection and consumer behavior.

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<sup>1</sup> Straw, Tara. "Direct Enrollment in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm; New 'Enhanced Direct Enrollment' Heightens Risks". *Center on Budget and Policy Priorities*. March 15, 2019. "["Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm \(cbpp.org\)](https://www.cbpp.org/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes-them-to-harm).

### Special Enrollment Verification

CMS proposes to establish requirements that state Exchanges conduct verification of a person's eligibility for a special enrollment period (SEP) for at least 75% of all SEPs for those individuals newly enrolling in Exchange coverage.

CMS notes that all state Exchanges already conduct pre-or post-enrollment verification for at least one special enrollment type, which indicates that they have identified those SEPs most vulnerable to errors and have targeted them for verification. We are concerned that these additional verification requirements may be unnecessary and will increase burden for individuals and Exchanges, resulting in a loss of coverage among those who are legitimately eligible.

The FAH strongly encourages CMS to ensure that SEPs are not made to be overly burdensome or complicated. CMS should monitor SEPs in all states to ensure that pre- or post-enrollment verification is not made so administratively burdensome that it impedes coverage.

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 any over-reliance on SEPs and mitigate the potential risk that the market may experience if large numbers of individuals are enrolling in coverage during a SEP rather than during regular open enrollment.

### *III.E.4. – Part 156 – Health Insurance Issuer Standards, Including Standards Related to Exchanges*

#### Maximum Annual Limitation on Cost Sharing for Plan Year 2022

The FAH notes with alarm the 6.4% increase over the 2021 Maximum Annual Limitation on Cost Sharing. This increase represents an increase from \$8550 maximum in 2021 to \$9100 in 2022 for self-only coverage. For coverage other than self-only coverage, the maximum cost sharing for 2022 is \$18,200, an expense that is frequently beyond a family's ability to pay.

While the FAH understands these increases are driven by statute and regulatory formulas, these annual expenditures are largely unaffordable to many with coverage under the ACA. These high cost-sharing amounts also negatively impact hospitals as amounts that patients cannot afford frequently remain unpaid and result in hospital bad debt. We urge CMS and policy makers to continue to explore ways to make coverage broader and more affordable.

#### Network Adequacy Standards

The proposed rule seeks to clarify that 45 CFR 156.230 does not impose network adequacy certification requirements for Qualified Health Plans (QHPs) that do not use a provider network. The primary example of such a plan is an indemnity plan. The FAH maintains that network adequacy is just one indicator of whether a plan beneficiary has access to essential health benefit

(EHB) services offered in a QHP plan. An indemnity plan that offers benefits for services that cannot be accessed does not satisfy the requirements of the ACA. Additionally, the proposed exception reads to apply if the plan or QHP does not differentiate benefits with the provider (singular) that furnishes covered services. Our understanding of this exception is that it would apply only if a plan's benefits are offered on an undifferentiated basis for all services, not just one service (singular).

The FAH would suggest the following modification to the language of the proposed rule to assure that where benefits are offered with no contractual agreement with providers, that access to those services is available:

- (f) Paragraphs (a) through (e) of this section do not apply to a plan for which the issuer seeks QHP certification or to any certified QHP that does not use a provider network, meaning that the plan or QHP does not condition or differentiate benefits **or access to providers of covered services** based on whether the issuer has a network participation agreement with any providers that furnish covered services.

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

#### Medical Loss Ratio Proposals

The FAH supports CMS' proposal to specifically define prescription drug rebates and price concessions, which are reported as non-claim costs in calculating a plan's medical loss ratio. We agree that these definitions will support consistent reporting across issuers and more accurately reflect enrollee prescription costs. While we appreciate the benefits to individual beneficiaries that come from these proposals, we urge CMS to continue to work toward addressing the high cost of prescription drugs at the manufacturer level.

The FAH also supports the flexibility offered issuers during the COVID-19 public health emergency targeted toward providing greater flexibility in providing premium credits and fostering continuity of coverage.

### *IV. State Innovation Waivers*

The FAH opposes CMS' proposal to incorporate and codify by reference guidance issued for states requesting waivers under section 1332 of the ACA. The guidance, issued in October of 2018, promotes state waiver projects that enroll individuals into ACA non-compliant plans such as short-term limited duration coverage or plans that exclude coverage for pre-existing conditions. It weakens the ACA's statutory "guardrails," which were intended to prevent 1332 waivers from reducing coverage or making coverage less comprehensive or less affordable.

Under section 1332 of the ACA, states can seek approval to pursue alternative coverage approaches in the individual and small group markets that are consistent with the goals of the ACA. The October 2018 guidance relaxed the standards for meeting the guardrails. By codifying the guidance, we expect that more individuals could be left without insurance coverage or with substandard coverage and that uncompensated care will increase.

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Thank you for the opportunity to comment on the proposed rule. If you have any questions, please contact me or a member of my staff at 202-624-1534.

Sincerely,

A handwritten signature in black ink, written in a cursive style. The signature is somewhat stylized and difficult to read, but it appears to be a name followed by a title or affiliation. The signature is positioned below the word "Sincerely,".