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December 30, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-9914-P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates To State Innovation Waiver (Section 1332 Waiver) Implementing Regulations

Dear Administrator Verma:

The American Kidney Fund appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule referenced above.

The American Kidney Fund (AKF) fights kidney disease on all fronts as the nation's leading kidney nonprofit. AKF works on behalf of the 37 million Americans living with kidney disease, and the millions more at risk, with an unmatched scope of programs that support people wherever they are in their fight against kidney disease—from prevention through transplant. Through programs of prevention, early detection, financial support, disease management, clinical research, innovation and advocacy, no kidney organization impacts more lives than AKF. AKF is one of the nation's top-rated nonprofits, investing 97 cents of every donated dollar in programs, and holds the highest 4-Star rating from Charity Navigator and the Platinum Seal of Transparency from GuideStar.

New Exchange Direct Enrollment (DE) option

On November 1, 2020, CMS approved Georgia's section 1332 waiver which will allow the state to end its participation in HealthCare.gov and instead privatize the enrollment function, with consumers able to shop only through a decentralized network of private insurers, brokers, agents and web-brokers. In this proposed rule, CMS proposes to allow other states to choose this Exchange Direct Enrollment (Exchange DE) option without having to submit and receive approval for a section 1332 waiver. AKF strongly opposes this proposal because it violates statutory requirements of the Affordable Care Act (ACA), and because of the likely adverse impact on people's ability to compare available plans and enroll in coverage that best fits their needs.

Under the proposed rule, a state that transitions to the Exchange DE option would provide a rudimentary website that displays basic plan information without a means to enroll, then direct people to private websites to complete the application. This is in violation of the statutory requirement in section 1311(d)(2) of the ACA, which requires an Exchange to “make available qualified health plans to qualified individuals.” In general, individuals would not be able to enroll in qualified health plans through the state website—they would have to enroll directly with a DE entity such as an insurer, broker, agent or web-broker.

The statutory requirement cited above and others related to it are why Georgia submitted a section 1332 waiver and why CMS waived those specific ACA requirements in order for Georgia to proceed with its Exchange DE option. With CMS’ proposal to allow other states to choose an Exchange DE option without going through the waiver process, the proposed rule would not only conflict with statutory requirements but also deprive consumers of the state and federal public comment periods that are mandatory for 1332 waivers.

In terms of consumer impact, allowing states to transition to the Exchange DE option will likely lead to lower enrollment in comprehensive coverage due to brokers’ reluctance to refer people to plans that do not pay commissions or to Medicaid, increased pressure for consumers to enroll in short-term limited duration insurance (STLDI) and other sub-par plans, and consumer confusion during the transition.

Currently, the Exchanges serve as a centralized one-stop-shop where people can fill out an application, determine their eligibility for advance premium tax credits (APTCs) or Medicaid and CHIP, compare qualified health plans (QHPs), and enroll in a QHP. With Exchange DE, we have significant concerns that DE entities such as agents and brokers will be incentivized to enroll individuals in plans that result in a higher commission or a bonus, but may not be the best plan option for the individual’s financial and health care needs. Reporting has demonstrated that the sale of STLDI plans, which provide far less coverage and leave enrollees financially vulnerable if they need medical care, can result in much higher broker commissions compared to commissions for the sale of QHPs.¹ Equally concerning is that under the Exchange DE proposal, agents and brokers are not required to inform a consumer that they may be eligible for Medicaid or CHIP, and could potentially steer them away from lower-cost, high quality coverage.

CMS also proposes changes to standards for DE and Enhanced Direct Enrollment (EDE) entities that will create additional confusion for consumers enrolling in coverage through the DE pathway. CMS proposes to require DE entities that market on-Exchange QHPs, off-Exchange plans, and other products (such as excepted benefits) to display information about these different plan types on three different webpages. However, CMS proposes to allow off-Exchange QHPs and non-QHPs to be displayed on the same webpage. CMS also proposes exceptions that would allow DE entities to

¹ Appleby J. Short-Term Health Plans Boost Profits For Brokers And Insurers. *Kaiser Health News*. <https://www.npr.org/sections/health-shots/2018/12/21/678605152/short-term-health-plans-boost-profits-for-brokers-and-insurers>. Published December 21, 2018.

display on-exchange QHPs, off-exchange QHPs, and other individual health insurance coverage options on the same webpage.

Additionally, CMS proposes new flexibilities for web-brokers that will allow them to obscure plan details and display less information for QHPs that are not sold through their website. Specifically, if a web-broker does not sell a certain QHP because it does not have an agreement with an insurer to enroll people in its products, the web-broker would no longer have to display a summary of benefits and coverage, quality ratings, or other information for that QHP. Currently, all web-brokers must display all available information for all health plans that are available to the consumer.

Ultimately, these new flexibilities for DE entities and loopholes for the display of information for different on-Exchange QHPs, off-Exchange QHPs, non-QHPs, and ancillary products will cause unnecessary consumer confusion, hinder people's ability to choose the plan that is right for their needs, and may lead to individuals enrolling in subpar coverage.

We strongly urge CMS to withdraw its Exchange DE proposal.

Codification of the 2018 Guidance on Section 1332 Guardrails

AKF opposes CMS' proposal to codify the 2018 guidance on the statutory guardrails for waiver applications under section 1332 of the ACA, and we strongly urge CMS to withdraw it. As we stated in our comment [letter](#) in response to the guidance, we believe it conflicts with the congressional intent of section 1332 and the plain reading of the statute, which outlines four clear guardrails that must be met for a waiver to be approved: coverage must be as affordable as it would be without the waiver; coverage must be as comprehensive as it would be without the waiver; a comparable number of people must be covered under the waiver as would be without it; and the waiver must not add to the federal deficit. Even more concerning is the adverse impact codification of the 2018 guidance will have on the stability of ACA Exchanges, comprehensiveness and affordability of coverage, pre-existing condition protections, and the protection of vulnerable populations in states that pursue and receive approval for a 1332 waiver under this guidance. Under the 2018 guidance, people with serious health risks, such as those with chronic kidney disease, could encounter higher costs for ACA-compliant insurance and fewer subsidies to pay for that insurance. A person with chronic kidney disease relies on comprehensive coverage to manage their condition and prevent a progression to end-stage renal disease (ESRD). A waiver that adversely affects their ability to maintain affordable and comprehensive insurance could lead to them dropping coverage.

Premium Adjustment Percentage Index and Maximum Annual Limitation on Cost-Sharing

CMS proposes to maintain the same premium adjustment percentage index methodology that it revised and adopted in 2019. We urge CMS to revisit this methodology and make revisions in this important area that has a significant impact on consumer out-of-pocket costs. The methodology will continue to result in greater rates of increase in out-of-pocket costs for individuals and families than would have occurred absent the 2019 change.

If continued, the formula change will have an even greater impact in 2022, raising premiums by an estimated 4.7 percent for most subsidized marketplace consumers after accounting for their tax credits (compared to about 2.7 percent this year). That amounts to a \$360 annual premium increase for a family of four with \$80,000 in income.

The same formula change also increases the limit on consumers' total out-of-pocket expenses, which applies to both Marketplace and employer plans. In 2022, that limit will be \$400 higher for an individual, and \$800 higher for families, than if the 2019 change were reversed.

These increased costs have a disproportionate effect on individuals and families who have serious and chronic conditions that require more health care services. They may forgo or delay care, which can lead to harmful complications and more costs. We ask that CMS revise the premium adjustment percentage index methodology so that it does not unnecessarily accelerate and further shift increased costs on to consumers.

Marketplace User Fee

The proposed rule would cut the federal marketplace user fee by 25 percent, from 3 percent to 2.25 percent and would cut the user fee for state-based marketplaces that use the federal platform from 2.5 percent to 1.75 percent. We oppose these proposed reductions.

The Marketplace user fee — a fixed percentage of premium revenue paid by insurers — supports critical functions, including the operation and improvement of the HealthCare.gov website, the Marketplace call center, the Navigator program, consumer outreach, and advertising. Consumer outreach and enrollment assistance functions are particularly important for individuals with complex health care needs such as people with chronic kidney disease and other comorbidities, as well as people who have been uninsured or underinsured and need help navigating their options in the Marketplace.

The proposed rule's rationale for the cut is that the lower user fee would be sufficient to fund current Marketplace activities. But current activities are inadequate. Under the current Administration, CMS has virtually ceased marketing and outreach and has slashed funding for Navigators, core Marketplace functions funded by user fees. Rather than cutting the user fee, it should be increased in order to restore outreach and enrollment assistance programs and to fund continued improvements to HealthCare.gov, including technological enhancements and improved customer service.

Special Enrollment Periods

CMS proposes refinements to special enrollment period (SEP) policies that we believe will help people retain affordable, comprehensive coverage. The need for SEPs to effectively respond to a person's changed insurance situation has been particularly acute during the COVID-19 public health emergency, and we generally support CMS' proposed SEP changes, with some recommended modifications.

We generally support the proposal to allow current Exchange enrollees and dependents to enroll in a new QHP of a lower metal level if they qualify for a SEP because they became newly ineligible for APTC. However, we recommend that CMS allow newly APTC-ineligible enrollees to use their SEP to enroll in a plan that is either a lower or higher metal level. While some healthier individuals or families may want to choose a lower metal plan with a lower monthly premium in order to retain coverage, other individuals or families with greater health needs may find that a higher metal plan with a lower out-of-pocket maximum may be a better fit for their situation. This additional flexibility would not increase the risk of adverse selection and would better ensure enrollees could choose a plan that is right for them.

We support CMS' proposal to allow an individual who did not receive timely notice of an SEP triggering event and was otherwise reasonably unaware that a triggering event occurred to select a new plan within 60 days of the date that they knew, or reasonably should have known, about the triggering event. The proposed change will provide greater opportunity for individuals to maintain coverage due to a triggering event and promote continuity of coverage.

Finally, we support CMS' proposal to designate the cessation of employer contributions for COBRA continuation coverage as a triggering event for SEP eligibility throughout the individual market. However, we recommend that CMS modify the proposal to also allow SEP eligibility when an employer reduces, but does not completely cease, its contributions for COBRA continuation coverage. For example, if an employer contribution is reduced from 100 percent to 15 percent per month, there is not much distinction between that reduction and a complete cessation of employer contribution. The threshold for the level of reduction to trigger the SEP should be based on whether the reduction in employer contribution renders the premium unaffordable to the enrollee considering their monthly income.

Thank you for your consideration of AKF's comments and recommendations.

Sincerely,



LaVarne A. Burton
President and CEO