



March 2, 2020

The Honorable Alex Azar
 Secretary
 U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Washington, DC 20201

The Honorable Seema Verma
 Administrator
 Centers for Medicare & Medicaid Services
 P.O. Box 8016
 Baltimore, MD 21244

RE: Comments to CMS-9916–P
 HHS Notice of Benefit and Payment Parameters for 2021

Dear Secretary Azar and Administrator Verma:

Thank you for the opportunity to submit comments on the Department of Health and Human Services (HHS or the Department) Notice of Benefit and Payment Parameters for 2021 (NBPP) proposed rule.

The undersigned organizations represent millions of patients facing serious, acute, and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness, and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an

invaluable resource in this discussion. We urge the Department to make the best use of the knowledge and experience our patients and organizations offer in response to this proposed rule.

In 2017, our organizations agreed upon three overarching principles¹ to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including the services in the essential health benefit package; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care. Enrollment should be easy to understand, and benefits should be clearly defined.

Using these principles as our benchmark, our organizations are deeply concerned about several of the policies and changes included in the proposed rule and their potential impact on the communities we represent and serve. We offer specific comments on the NBPP in the following areas:

Automatic Re-enrollment Process

Suggesting, without support, that the process for automatically re-enrolling consumers in marketplace coverage may “potentially lead” to government misspending and “general consumer confusion,” the Department sought comment in last year's proposed NBPP about whether to pursue changes to that process in future years. In response, commenters voiced unanimous support for automatic re-enrollment and explained why that process and a range of other existing enrollment and eligibility mechanisms both aid consumers and safeguard federal spending. Yet despite this public record, and the continued inability of the Department to point to any evidence suggesting that automatic re-enrollment is a danger to consumers or the federal budget, the 2021 NBPP asserts the Department is still concerned about the process. More than that, it proposes to modify automatic re-enrollment in a manner that targets low-income Americans and jeopardizes their health coverage. We strongly oppose this effort.

According to the proposed rule, during the 2019 open enrollment period, approximately 270,000 individuals were automatically reenrolled through HealthCare.gov in coverage with zero premiums, after the application of premium tax credits. The Department proposes that such individuals — people with household incomes sufficiently low so that they receive financial assistance that completely covers plan premiums — be treated differently from other consumers and be re-enrolled without the benefit of the premium tax credits for which they are eligible. If implemented, this proposal would expose these low-income consumers to unexpected bills and the risk that their coverage will be terminated for nonpayment of a premium they cannot, by definition, afford. By requiring one group of consumers to go through a new eligibility determination process or pay a much higher premium, the new policy would effectively eliminate automatic re-enrollment for this vulnerable population. Though the Department claims it will engage in outreach to alert consumers that they can no longer count on automatic re-enrollment and may face a sudden prohibitively steep increase in their

premium, the proposed rule offers no reason to believe such efforts will be sufficient to offset what is likely to be considerable consumer confusion. The result is likely to be that some of these low-income consumers will lose health coverage, shrinking the private market risk pool.

We strongly urge the Department to withdraw this proposal and ensure that automatic re-enrollment remains a viable option for all enrollees.

Special Enrollment Periods

Special enrollment periods (SEPs) provide consumers a critical opportunity to enroll in coverage appropriate to their needs when their circumstances change during the course of the year. With this in mind, we strongly support the Department's proposal to allow silver-plan enrollees who gain access to a SEP because they are newly ineligible for cost-sharing reductions to switch enrollment to a bronze or gold-level QHP. This change would provide such consumers greater flexibility to enroll in a marketplace health plan that is suited to their needs in light of their changed financial circumstances.

We also support the proposal to modify the rules governing the effective date of coverage for certain SEPs to require issuers to effectuate coverage on the first day of the month following plan selection. As the proposed rule recognizes, this change would allow consumers to enroll more rapidly in appropriate coverage, reducing both the likelihood that individuals will experience gaps in coverage and the length of such gaps when they do occur. The change, which would harmonize coverage effective dates for many of the most common SEP triggers, is also likely to reduce consumer confusion regarding the special enrollment process.

Finally, we support the remainder of the proposed changes to SEP rules contained in the NBPP. We believe these proposals will offer greater flexibility to consumers and reduce barriers to enrolling in comprehensive individual market coverage.

Medical Loss Ratio and Wellness Programs

HHS is proposing to allow issuers in the individual market to count spending on certain wellness incentives as Quality Improvement Activities (QIA) when calculating their Medical Loss Ratio (MLR). While this would align individual market MLR rules with those that apply to group health plans that offer wellness programs, HHS is proposing the change to "ensure...access to wellness programs" under the ten-state wellness program demonstration project announced last September. As noted in our letter of November 21, 2019, wellness programs available in employer-based plans have been found ineffective in lowering costs or improving health outcomes.² As such, wellness programs should not be considered a Quality Improvement Activity because they have been shown to be ineffective at achieving their goals of improving health and lowering costs. Further, wellness programs raise the potential for discrimination against patients with serious and chronic health conditions such as those we represent. Despite these concerns, HHS has invited states to participate in the demonstration program without requiring states to submit data that would be needed to evaluate the programs. Nor is there any requirement that states seek public comment on proposals to participate in the wellness

program demonstration project. We continue to oppose the demonstration project and urge HHS to rescind the bulletin inviting states to submit proposals for approval.

Premium Adjustment Percentage Index

Under the revised methodology adopted last year, the premium adjustment percentage index will grow more quickly and shift ever-greater costs onto families than would have occurred previously. HHS said, in proposing the change in last year's payment notice, this result will reduce "economic distortions" by requiring individuals to bear a greater share of their health care costs and reduce costs for the federal government. For individuals and families enrolled in individual or employer-based coverage, the burden is substantial: the proposed 2021 annual limit on cost-sharing is \$8,550 for self-only coverage and \$17,000 for other than self-only coverage. These increased costs will disproportionately impact patients who use more health care services and do not include the out-of-pocket costs paid for non-covered or out-of-network care. Some individuals facing these enormous costs will choose to forgo necessary care, leading to costly and dangerous complications. For the reasons we raised in our comments on the proposed change last year, we continue to oppose the changes made to the methodology and urge the Administration to revise their policy in this critical area.³

Our organizations urge you to strengthen the proposed rule and remove provisions that would undermine accessible, adequate, and affordable healthcare coverage for patients with serious and chronic health conditions. Thank you for the opportunity to submit comments on this important rule.

Sincerely,

American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
COPD Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Leukemia & Lymphoma Society
Lutheran Services in America
Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Coalition for Cancer Survivorship
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation

Pulmonary Hypertension Association
Susan G. Komen
United Way Worldwide

¹ American Heart Association website, “Healthcare reform principles,” available at: http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf.

² Letter to Secretary Azar, Nov. 21, 2019, available at: <https://www.lung.org/assets/documents/advocacy-archive/partners-letter-to-hhs-re.pdf>.

³ Letter to Secretary Azar, Feb. 19, 2019, available at: <https://www.lung.org/assets/documents/advocacy-archive/partners-comments-to-hhs-re.pdf>.