American Lung Association.

December 21, 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: 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 Secretary Azar and Administrator Verma:

The American Lung Association appreciates the opportunity to submit comments on the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters (NBPP) for 2022 proposed rule.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the nearly 37 million Americans living with lung diseases including asthma, lung cancer and COPD. As such, the Lung Association is uniquely positioned to comment on the impact this proposed rule will have on lung disease patients.

Unfortunately, a number of provisions in the proposed rule could jeopardize healthcare coverage and increase healthcare costs for patients. The Lung Association therefore urges HHS to modify the proposed rule in the following areas.

Elimination of Enrollment Options through Healthcare.gov

The proposed rule would allow states to solely use private sector entities for enrolling people in healthcare coverage rather than using Healthcare.gov or a state-based exchange. This proposal, if finalized, would likely create confusion for patients, reduce enrollment in comprehensive coverage and jeopardize access to quality and affordable healthcare for patients with lung diseases. It would limit patients' ability to compare the price and benefit design of qualified health plans (QHPs), in addition to masquerading non-compliant plans as a viable option for patients with lung disease. Patients and consumers who become enrolled in substandard health insurance coverage could experience denial of coverage for pre-existing conditions and lose key financial protections. This failure to appropriately shield consumers, particularly those with pre-existing conditions, from these outcomes is unacceptable. The Lung Association strongly urges the Administration not to finalize this provision of the proposed rule.

Currently, states have the choice to participate in the federally facilitated exchange or create their own state-based exchange. Healthcare.gov serves as a simple, national website to help

Americans enroll in coverage, either through the site itself or directing people to their state-based exchange. Both Healthcare.gov and the state-based exchanges have safeguards built into the system to help ensure patients and consumers compare options and choose a plan that is the best option for them. They also identify patients and consumers who are eligible for Medicaid, CHIP or Medicare and direct them to the appropriate enrollment process. In contrast, relying solely on private entities to enroll patients in coverage could discourage[1] Medicaid and CHIP enrollment, resulting in low-income Americans paying more for coverage or forgoing healthcare coverage all together.

Healthcare.gov and state-based exchanges currently calculate advanced premium tax credits (APTC) and eligibility for cost sharing reduction (CSR) silver plans, allowing consumers to accurately compare costs between different plans and metal levels. The proposed rule would still require a state to participate in Healthcare.gov or maintain their state-based exchange to calculate and issue the APTCs and CSRs, but there is no requirement that consumers would see the full plan and cost information on an insurer or web broker website. Additionally, insurers or web-brokers would not be required to list out all the QHPs available to a consumer shopping for health insurance. The proposed rule would only require the insurer or web-broker to link to other plans or add a disclaimer that other plans are available at Healthcare.gov. Brokers frequently receive bonuses from insurers for signing consumers up for certain plans, creating an incentive for brokers to enroll individuals in plans that may not be the best option for them. This dynamic does not encourage people to make informed decisions about their healthcare needs and is not in the best interest of patients with lung disease.

Relying on insurers and web brokers for enrollment may also expose patients and consumers to non-QHP plans - including substandard options such as short-term and association health plans. Currently, every plan sold on healthcare.gov is a QHP, meaning it covers the ten essential health benefits (EHB) – including maternity care, emergency room services and preventive services. Today, consumers can trust that they are purchasing a health insurance plan that will cover their medical needs to manage their health condition. Insurers and web-brokers selling both QHP plans and non-QHP plans may steer consumers into the less comprehensive plans with the lure of lower premiums. These non-comprehensive, skimpy health plans do not cover the services and treatments that lung disease patients need to manage their conditions. There is also widespread evidence of misleading marketing related to short-term and other skimpy plans leading individuals to unwittingly enroll in coverage that lacks key patient protections.[2]

Finally, ending enrollment through Healthcare.gov will inevitably lead to coverage losses. Even much more straightforward changes to state marketplaces have led to enrollment declines. For example, when Nevada transitioned from the federal marketplace to its own enrollment platform, a transition years in the making that by all accounts went smoothly, the state still saw an enrollment decline of 7%.[3] The changes permitted under the proposed rule would put an even greater strain on current enrollees than what was experienced in previous marketplace transitions. Under the circumstances, it is reasonable to expect enrollment declines in excess of those seen in Nevada and other states that have shifted enrollment platforms. The Lung Association is deeply concerned about these coverage losses and urges the Administration not to finalize this provision in the final rule.

Other Direct Enrollment Concerns

The proposed rule would allow enrollment assisters and navigators to use direct enrollment websites in addition to Healthcare.gov, as well as allow state-based marketplaces to choose whether to implement the same policy. Given the risks to consumers from these websites as outlined above, the Lung Association opposes this change. Assisters and navigators are trusted people in the community and should use non-biased enrollment tools to help consumers choose the best plan for them. Additionally, using direct enrollment sites will be more time consuming because all of the information is not required to be readily available to compare prices and plans on these enrollment platforms.

The proposed rule would also allow these enhanced direct enrollment websites up to 12 months to translate website content into languages spoken by populations that make up at least 10% of the total state population. The Lung Association is concerned that this change will make it harder for limited English proficient (LEP) populations to enroll in quality and affordable healthcare coverage. LEP populations already have greater challenges understanding and accessing healthcare, and these changes would only serve to exacerbate existing health disparities. The Lung Association urges the Administration not to finalize this provision of the rule.

1332 Waiver Guidance

Section 1332 waivers allow states to waive specified provisions of the Affordable Care Act (ACA), provided the state's waiver plan meets four statutory guardrails: 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. In 2018, HHS and Treasury issued new State Relief and Empowerment Waivers guidance, followed by a Section 1332 State Relief and Empowerment Waiver Concepts Discussion Paper, that supersedes guidance from 2015 for states on how to design these waivers.

Unfortunately, as the Lung Association and other patient advocacy organizations wrote in detailed comments submitted to HHS and Treasury in December 2018,[4] the policies that states could pursue under the new guidance would significantly undermine quality and affordable healthcare for patients with pre-existing conditions. The guidance will make it easier for states to use federal taxpayer dollars to promote sub-standard plans that do not provide comprehensive and affordable coverage. And it tips the scales in favor of insurance products that are inadequate to meet the needs of the millions of patients and consumers our organizations represent. The Lung Association reiterates our request that HHS and Treasury rescind this guidance and we strongly oppose the codification of this guidance through the proposed rule.

Essential Health Benefits

As we noted in our comments in previous years,[5] the Lung Association has grave concerns with the Administration's policy aimed at weakening essential health benefit (EHB) requirements in the 2019 Notice of Benefit and Payment Parameters, allowing states to mix and match benefit structures in a way that could reduce patients' access to care. The Lung Association is concerned that the changes allowed under this policy, combined with other administrative actions finalized by the Administration such as the de-regulation of association health plans and short-term plans combined with the new guidance on 1332 waivers, could allow states to loosen patient protections. This policy gives states authority to offer not just less generous coverage, but the *least* generous coverage – jeopardizing the integrity of the ACA and the policies that

underpin quality and affordable healthcare. The Lung Association reiterates our ask that HHS reverse these harmful policies.

Premium Adjustment Percentage Index

Under the revised methodology adopted for the 2020 plan year, the premium adjustment percentage index will grow more quickly and increase the maximum out of pocket costs (MOOP) allowed for all private insurance enrollees, including those with employer-sponsored coverage. For individuals and families enrolled in individual or employer-based coverage, the burden is substantial: the proposed 2022 annual limit on cost-sharing is $9,100 for self-only coverage and $18,200 for other than self-only coverage. The Lung Association fears that more patients will be forced to choose between massive medical bills and forgoing needed care, leading to worse health outcomes and increased costs for the health system.[6] As we noted in previous comments,[7] this impact will only worsen over time, as the MOOP continues to increase at a faster rate than it would have absent a change in policy. We once again urge the Administration to revise their policy in this critical area.

User Fees

The proposed rule would significantly reduce user fees for the federally facilitated marketplace and state-based marketplaces that use the federal platform. The Lung Association is concerned that these changes would significantly limit investments in outreach and enrollment activities and other changes that could improve the operation of marketplaces for patients. Robust outreach and enrollment efforts are critical to helping patients with lung disease learn about their healthcare coverage options and enroll in plans that are appropriate for their healthcare needs. These activities are more important than ever during the COVID-19 pandemic as millions of Americans have lost their jobs, putting their access to employer-sponsored health insurance coverage at risk.[8] Outreach and enrollment activities are also critical for eliminating disparities in healthcare coverage, as individuals with low incomes and racial and ethnic minorities are more likely to be unaware of their options for coverage through the marketplaces.[9] The Lung Association therefore urges the Administration not to finalize these changes to marketplace user fees.

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, the Lung Association support the Department's proposals to allow an enrollee to change to a plan of a different metal level due to a change in eligibility for APTCs, and to open an SEP if an individual's employer eliminates or reduces its contribution to coverage through COBRA. These changes 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.

However, the Lung Association is concerned by the Administration's proposal to require state-based marketplaces to conduct SEP verification for at least 75 percent of new enrollments. While the Lung Association supports program integrity, we are troubled by the timing of this change as our country continues to tackle the COVID-19 pandemic. SEP documentation requirements can be burdensome for consumers who legitimately qualify for a SEP, and this burden can be especially significant given the complications of gathering needed information and documentation during the pandemic. The Lung Association urges the Administration not to finalize this provision of the proposed rule.

Conclusion

The American Lung Association appreciates the opportunity to submit comments on this important rule. We urge HHS not to finalize the provisions outlined above and to keep patients in the forefront when creating new policies that impact the accessibility, adequacy and affordability of healthcare.

Sincerely,

Harold P. Wimmer
National President and CEO

---

[1] Tara Straw, "'Direct Enrollment' in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm." Center on Budget and Policy Priorities. March 15, 2019. Available at: https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes

[2] Seeing Fraud and Misleading Marketing, States warn Consumers About Alternative Health Insurance Products. The Commonwealth Fund, Dania Palanker, JoAnn Volk, and Maanasa Kona. October 30, 2019. Available at; https://www.commonwealthfund.org/blog/2019/seeing-fraud-and-misleading-marketing-states-warn-consumers-about-alternative-health, and The Marketing of Short-Term Health Plans, The Robert Wood Johnson Foundation, January 31, 2019. Available at: https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html

[3] Nevada health insurance marketplace: history and news of the state's exchange. Louise Norris, HealthInsurance.org. June 11, 2020. Available at: https://www.healthinsurance.org/nevada-state-health-insurance-exchange/

[4] [4] Health Partner Letter to HHS re 1332 Guidance. December 18, 2020. Available at: https://www.lung.org/getmedia/fd7ca753-c9f3-4db5-83a1-14732cdaa6ef/health-partner-comments-re-2.pdf.pdf

[5] American Lung Association, Comments on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, Feb. 19, 2019. Available at: https://www.lung.org/getmedia/cc2b41e8-376e-44dc-a531-2dc7a74e0bdd/american-lung-association-32.pdf; American Lung Association, Comments on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021, March 2, 2020. Available at: https://www.lung.org/getmedia/2ad1c60a-0f00-4f5c-8e74-dae902db4962/lung-nbpp2021.pdf.

[6] Multiple studies for the Medicaid population bare this out. See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. J Gen Intern Med. 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings." Center on Budget and Policy Priorities (July 2005), available at http://www.cbpp.org/5-31-05health2.htm.

[7] American Lung Association, Comments on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, Feb. 19, 2019. Available at: https://www.lung.org/getmedia/cc2b41e8-376e-44dc-a531-2dc7a74e0bdd/american-lung-association-32.pdf; American Lung Association, Comments on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021, March 2, 2020. Available at: https://www.lung.org/getmedia/2ad1c60a-0f00-4f5c-8e74-dae902db4962/lung-nbpp2021.pdf.

[8] Paul Fronstin and Stephen A. Woodbury. "How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?" The Commonwealth Fund. October 7, 2020. Available at:https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/how-many-lost-jobs-employer-coverage-pandemic

[9] Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty. Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage? Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–June 2017. The Commonwealth Fund. Accessed at: https://www.commonwealthfund.org/publications/issue-briefs/2017/sep/following-aca-repeal-and-replace-effort-where-does-us-stand.