



December 23, 2020

Alex M. Azar II
Secretary, Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Seema Verma
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

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 Secretary Azar and Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 136,700 family physicians and medical students across the country, I appreciate the opportunity to provide comments on the [proposed rule](#) on the plan year 2022 Notice of Benefit and Payment Parameters as published in the December 4, 2020 version of the *Federal Register*.

The Affordable Care Act (ACA), and specifically the creation of the individual market, has improved access to the affordable, comprehensive, and continuous primary care services that family physicians provide.^{1,2} The AAFP firmly believes that everyone in the United States should have access to these vital services and therefore we remain committed to building upon the successes of the ACA.³ We are concerned that several of these proposals run counter to these goals and would undermine patients' ability to obtain meaningful health care coverage and access to primary care. **The AAFP strongly recommends against finalizing this rule as proposed.**

Establishing Enhanced Direct Enrollment Option

HHS proposes to establish a process for states to opt out of using a single, centralized exchange (for most states, HealthCare.gov) and instead use only private sector entities to enroll individuals. Under this option, known as Exchange Direct Enrollment private entities, insurers, web brokers, and agents and brokers, would operate enrollment pathways where consumers would shop, select a plan, and enroll in coverage. While the exchange would still have to maintain a website with various basic information and would be responsible for back-end enrollment processes, like conducting eligibility determinations and verifying applicant information, shopping and enrolling for plans would be done solely through private entities. **The AAFP is deeply concerned that this proposal will increase the**

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number of uninsured individuals across the nation, erode affordable access to primary care, and negatively impact health outcomes. As such, we urge HHS not to finalize this proposal.

This proposal mirrors Georgia's recently approved 1332 waiver request to opt-out of HealthCare.gov and instead require individuals to use private insurance companies and brokers to compare plans, apply for financial assistance, and enroll in coverage. In this proposed rule, HHS proposes to extend this option to all states without going through the waiver process. The Georgia Academy of Family Physicians [submitted comments](#) to the proposed waiver and raised significant concerns with its impact on consumers and the stability of Georgia's individual market. The AAFP has the same concerns with this proposal.

First, allowing states to opt-out of HealthCare.gov or eliminate their own exchange portal will complicate enrollment processes and increase burden on consumers, ultimately resulting in loss of coverage. Studies suggest that fragmenting the market across brokers and insurers would make enrollment more confusing for consumers and reduces enrollment.⁴ Additionally, most consumers currently enroll through the exchange – not through direct enrollment pathways. Direct enrollment pathways have been available for several years and account for only one-third of enrollment in the federally facilitated exchanges and have not increased overall enrollment, which has remained flat since 2016.⁵ The AAFP fails to see how eliminating the pathway through which most consumers enroll will lead to an increase in enrollment.

This proposal will also create barriers to Medicaid and Children's Health Insurance Program (CHIP) enrollment and therefore result in an increase in uninsured individuals. Data suggest that Medicaid coverage directly correlates with access to primary care: children and adults covered by Medicaid are much more likely to have a usual source of care than their uninsured or privately insured low-income counterparts.⁶ Currently, HealthCare.gov and state-based exchange websites facilitate Medicaid enrollment by seamlessly routing eligible individuals to the appropriate program. HHS indicates that, if a state chooses the Enhanced Direct Enrollment option, exchanges would still be responsible for conducting eligibility assessments for Medicaid and CHIP and referring eligible individuals to state Medicaid agencies. However, a recent analysis found that Medicaid-eligible individuals faced additional barriers when relying on a direct enrollment website.⁷ Brokers and insurers are incentivized to enroll individuals into private plans instead of connecting them to their state Medicaid agency. In fact, evidence indicates that web-brokers often fail to notify individuals that they are eligible for Medicaid or CHIP and will instead direct them to select a private plan.⁸

Relying solely on insurers and brokers will lead to less comprehensive coverage, raise premiums, and reduce competition in the individual market as consumers are steered away from qualified health plans (QHP). Direct enrollment entities often benefit from enrollment in short-term plans through higher commissions and profits, and therefore are incentivized to steer consumers into plans that do not offer comprehensive health benefits, including prescription drugs, maternity care, or behavioral health services.^{9,10} One analysis found that, even under current regulations, 1 in 4 marketplace enrollees that sought help from a broker or insurer said they were offered a non-ACA compliant plan as an alternative to marketplace coverage.¹¹ A recent Milliman report found that the proliferation of short-term plans has led to premium increases for ACA-compliant plans, likely because healthy people are drawn away from the marketplace for comprehensive coverage.¹²

Lastly, this proposal will expose more consumers to catastrophically high out-of-pocket costs, as well as misleading and deceptive practices.¹³ A recent investigation from the Government Accountability

Office (GAO) found that brokers engaged in deceptive practices, such as falsely claiming plans would cover treatment for pre-existing conditions, in 8 out of 31 calls.¹⁴ In another two of these calls, GAO found that brokers provided incorrect information, such as selling consumers non-ACA compliant plans without notifying them that they could instead buy an ACA-compliant plan with \$0 in premium costs.¹⁵ This is particularly concerning, since, under this proposal, low-income individuals who are ineligible for Medicaid but eligible for premium assistance will be directed to these direct enrollment entities to enroll in coverage. The AAFP has [long opposed](#) short-term plans and other health insurance options that do not provide adequate coverage for most individuals, particularly those with pre-existing conditions, to receive the full range of evidence-based primary care services.

Taken together, the proposal to allow states to opt-out of HealthCare.gov or providing their own exchange portal directly conflicts with AAFP policy, which explicitly calls for the required coverage of essential health benefits, the maintenance of consumer protections, and improving the affordability of comprehensive coverage. The AAFP strongly opposes this proposal and again urges HHS not to finalize it.

Special Enrollment Periods

Exchange Enrollees Newly Ineligible for Advanced Premium Tax Credit (APTC)

Currently, enrollees who lose eligibility for premium subsidies and want to change plans are required to select a plan in the same metal level. HHS proposes to add a new flexibility to allow current Exchange enrollees and their dependents to enroll in a new QHP of a lower metal level if they qualify for a special enrollment period due to becoming newly ineligible for APTC. For example, an enrollee with a gold level QHP that loses eligibility for APTC could enroll in a silver or bronze level QHP (or catastrophic coverage, if available). The AAFP agrees with HHS that this flexibility would promote continuous coverage for individuals who can no longer afford their current plan choice. As previously mentioned, we are strongly in favor of policies that improve affordability of comprehensive health coverage. The AAFP recommends that HHS finalize this proposal.

Untimely Notice of Triggering Event

HHS proposes to allow an individual enrollee, or dependent, 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. This would apply to any type of triggering event for both on- and off- exchange coverage and individuals could choose the earliest effective date that would have been available if they had received timely notice of a triggering event. The AAFP supports this proposal. We believe allowing an enrollee 60 additional days to choose a plan after they are made aware of a triggering event will prevent losses in coverage.

Medical Loss Ratio

The ACA requires health insurers to submit data on the proportion of premium revenues spent on clinical services and quality improvement. This proportion is known as the medical loss ratio (MLR). If the insurer does not meet minimum standards for the MLR, insurers are required to issue rebates to enrollees. The AAFP supports medical loss ratio MLR policies as they help ensure health care finances are focused on patient care rather than insurer profits.

HHS proposes to require insurers to deduct prescription drug rebates and other price concessions from incurred claims for MLR reporting and rebate calculations. The AAFP supports this proposal and believes it will improve the accuracy of the MLR and facilitate accurate calculations of rebates for enrollees.

The Department further proposes to permanently allow insurers to prepay MLR rebates to enrollees in the form of a premium credit or lump sum payment, beginning with the 2020 reporting year. The AAFP supports this proposal and commends HHS for its efforts to improve affordability for individual market enrollees amid the COVID-19 pandemic. We believe that allowing MLR rebates to be prepaid will provide flexibility for future crises, relief for enrollees, and help to maintain comprehensive health coverage.

Section 1332 of the ACA

Section 1332 of the ACA permits states to apply for state innovation waivers to pursue innovative strategies for providing access to high value, affordable health coverage. Under the guise of increasing state innovation, HHS proposes to codify into regulation a guidance document from 2018 which outlines how HHS would apply Section 1332 of the ACA to determine whether applications for Section 1332 waivers will be approved. The AAFP opposes this proposal and believes it is inconsistent with Section 1332 of the ACA.

[As we wrote in December 2018](#), the AAFP remains concerned that the 2018 guidance bolsters the availability of non-ACA complaint plans and encourages states to undermine the Medicaid program. Section 1332 clearly creates 1332 waiver authority to *improve* access to comprehensive health coverage, as offered by ACA-compliant qualified health plans and state Medicaid programs. The 2018 guidance also runs counter to AAFP policy, which mandates coverage of defined essential health benefits. As such, the AAFP urges HHS not to finalize this proposal.

Thank you for the opportunity to provide comments on the interim final rule. Should you have any questions or wish to discuss our comments further, please contact Meredith Yinger, Senior Regulatory Strategist, at myinger@aafp.org or 202-235-5126.

Sincerely,



Gary LeRoy, MD, FAAFP
Board Chair
American Academy of Family Physicians

¹ Courtemanche C, Marton J, Ukert B, Yelowitz A, Zapata D. Effects of the Affordable Care Act on Health Care Access and Self-Assessed Health After 3 Years. *Inquiry*. 2018;55:46958018796361. doi:10.1177/0046958018796361

² Schmittiel JA, et al. Improvements in Access and Care Through the Affordable Care Act. *Am J Manag Care*. 2017;23(3):e95-e97. Available at: <https://www.ajmc.com/view/improvements-in-access-and-care-through-the-affordable-care-act>

³ American Academy of Family Physicians. Health Care for All: A Framework for Moving to a Primary Care-Based Health Care System in the United States. 2018. Available at: <https://www.aafp.org/about/policies/all/health-care-for-all.html>

⁴ Straw T. Tens of Thousands Could Lose Coverage Under Georgia's 1332 Waiver Proposal. Center on Budget and Policy Priorities. 2020. Available at: <https://www.cbpp.org/research/health/tens-of-thousands-could-lose-coverage-under-georgias-1332-waiver-proposal#:~:text=Section%201332%20allows%20a%20state,known%20as%20pass%2Dthrough%20payments>.

⁵ Keith, K. The 2022 Proposed Payment Notice, Part 1: Exchange Provisions. Health Affairs. 2020. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20201127.118789/full/>

⁶ Paradise J. Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid. Kaiser Family Foundation. 2017. Available at: <https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/>

⁷ Straw T. "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm. Center on Budget and Policy Priorities. 2019. Available at: <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>

⁸ Ibid

⁹ Corlette S, et al. Perspective from Brokers: The Individual Market Stabilizes While Short-Term and Other Alternative Products Pose Risks. Urban Institute. 2020. <https://www.urban.org/research/publication/perspective-brokers-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks>.

¹⁰ Virgil Dickson, "Thousands of brokers exit HealthCare.gov as plan commissions go unpaid," *Modern Healthcare*, April 5, 2017, <https://www.modernhealthcare.com/article/20170405/NEWS/170409972/thousands-of-brokers-exit-healthcare-gov-as-plan-commissions-go-unpaid>.

¹¹ Karen Pollitz et al., "Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need," Kaiser Family Foundation, August 7, 2020, <https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/>.

¹² Hansen D and Dieguez G. The Impact of Short-Term Limited Duration Policy Expansion on Patients and the ACA Individual Market. Milliman. 2020. Available at: <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>

¹³ Ibid.

¹⁴ Government Accountability Office. Private Health Coverage: Results of Covert Testing for Selected Offerings. 2020. Available at: <https://www.gao.gov/assets/710/708967.pdf>

¹⁵ Ibid.