AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

February 18, 2019

VIA ELECTRONIC MAIL
regulations.gov

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-8013

Re: CMS-9926-P, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020

Dear Ms. Verma,

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to provide the following comments in response to the Notice of Benefit and Payment Parameters for 2020. Our organization is the policy voice of five Seventh-day Adventist affiliated health systems that include 84 hospitals and more than 300 other health facilities in 17 states and the District of Columbia. The mission of our faith-based, not-for-profit hospitals is to improve the health of our patients and communities.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to urban areas of California. With such diverse facilities, populations served and geographical locations, we strive to provide an objective and sound policy voice that works across health care providers.

Below, please find AHPA's comments and recommendations on CMS' proposed policies. Specifically, we comment on the following issue areas:

- Prescription Drug Benefits
- Cost-Sharing Requirements for Generic Drugs
- Navigator Program Standards
- Special Enrollment Period
- Contributions Percentages
- Premium Adjustment Percentages
- Transparency

Prescription Drug Benefits

CMS proposes to permit health insurers in the individual and group markets to make mid-year formulary changes when a new generic medication becomes available. Insurers would be required to send a written notice to enrollees 60 days prior to removing any drug from the formulary or moving the drug to a different tier. The notice should remind enrollees of the availability of the appeal and exception processes available to them.

While we commend the Agency's efforts to promote the use of generic drugs, we are concerned that this policy may jeopardize access to medically-necessary drugs. When prescribing drugs, physicians take into account the person's allergies toward a medication, the cross-reactivity among drugs and any potential side effects. While a generic drug may less expensive, such drug may not always result in the best outcome for the patient. Removing a medically-needed drug from the formulary or increasing its price mid-year would make it more difficult for patients to access and afford the care they need. For some patients with complex care needs, the brand-name drug may still be the most effective. AHPA is concerned that the proposed change would make the originally-recommended drug now unavailable and unaffordable for complex patients.

Cost-Sharing Requirements for Generic Drugs

CMS proposes to allow insurers in the individual, small group and large group markets to not count cost-sharing for brand-name drugs towards the maximum out-of-pocket limit when a generic version is available. CMS also proposes to allow insurers to apply annual and dollar limits to spending on brand-name drugs when an equivalent is available.

AHPA is concerned that this policy will jeopardize access to medically-necessary drugs and increase families' out-of-pocket expenses. AHPA also opposes the alternate proposal, which would allow issuers to completely exclude the entire amount paid by a patient for a brand drug from the annual cost-sharing limit, regardless of the cost of its generic equivalent. CMS is requesting comment on whether this exclusion of brand-name drugs should be mandated. **We do not believe that CMS should require issuers to exclude brand-name drugs from being an electronic health benefit if a generic alternative is available.** Rather, AHPA advises that issuers be given the flexibility to decide whether the exclusion of these drugs is appropriate for their consumers.

Navigator Program Standards

CMS proposes to discontinue requiring that Navigators provide post-enrollment services for consumers on the Health Insurance Exchanges. According to the Agency, removing such requirement as a condition of funding would give Navigators the flexibility to tailor their services and resources to fit the needs of their communities. This could involve conducting additional outreach or assistance to consumers enrolling in health coverage.

We commend the Agency for exploring ways to reduce administrative burden surrounding the Navigator program, however, we are concerned that dwindling grant funding will force programs to focus only on sustaining the required Navigator activities. Should post-enrollment assistance no longer be required, we advise that funding be preserved so that HHS' goal of more robust consumer assistance can be met for those who need it. The post-enrollment assistance provided by the Navigator program, such as assistance with eligibility appeals and counsel on health coverage rights, is still greatly needed. This is particularly true for the elderly and disabled populations that we serve.

Special Enrollment Period

CMS proposes a special enrollment period for off-Exchange enrollees who experience a decrease in household income and are determined to be eligible for advance payments of the premium tax credits by the Exchange.

AHPA supports the creation of this additional enrollment period and believes that its creation will alleviate patient financial burden. We agree that additional consumer instructions regarding acceptable documentation will be important to achieve the Agency's goal of promoting continuous coverage for individuals experiencing an income decrease.

Contribution Percentages

For 2020, CMS proposes to calculate premium growth differently than in past years by incorporating the growth of individual market insurance premiums into the premium growth estimates. This would result in a higher annual limit and required contribution. The increase to the required contribution percentage would be 0.09% higher than 2019, making the new 2020 required percentage 8.39%. By CMS'

calculations, this change would decrease Exchange enrollment by approximately 100,000 individuals each year between 2020 and 2023.[1]

AHPA opposes policies that reduce access to health care coverage. While we understand that the proposed change would result in savings for the federal government, we are concerned that this change decreases access for the most financially-vulnerable patients. Currently, individuals must maintain minimum essential coverage unless they are exempted because the coverage is unaffordable. The estimated 100,000 individuals affected by this policy would be required to spend a larger percentage of their income on premiums, resulting in them becoming uninsured. By CMS' admission, "[this] increased number of uninsured may increase federal and state uncompensated care costs."[2]

Transparency

CMS seeks comments on ways to provide consumers with greater transparency around the cost of health care services, as a greater understanding of costs promotes consumers' ability to shop for covered services and play a more active role in their health care. CMS is considering different options for disclosure of cost-sharing information, including requiring the disclosure of a consumer's anticipated costs.

AHPA applauds CMS for tackling the complexity surrounding price transparency. As we partner with CMS and other health care providers to achieve price transparency, we believe that the patient should be at the center of our efforts. With that in mind, we must provide meaningful information to patients to help them make educated health care decisions.

We recommend that CMS use both price and quality information to help consumers choose high-quality care. While hospitals are required to make available a list of their current standard charges in a machine-readable format, we believe that this requirement stops short of achieving *meaningful* price transparency. The main goal of price transparency should be to empower patients to make educated decisions about their care. For example, AHPA-member AdventHealth uses the Simplee platform to present patients with price information that is tailored to their specific medical needs and insurance plan. This allows patients to make better-informed decisions about upcoming care.

[1] Centers for Medicare and Medicaid Services, Proposed HHS Notice of Benefit and Payment Parameters for 2020 (p. 308)
[2] Ibid.

Nuanced price information must also be coupled with quality data to maximize its efficacy. Without it, individuals are most likely to assume that higher prices mean better care.[3] The quality information provided should be risk adjusted so that hospitals serving more vulnerable populations are not penalized.

AHPA also urges the Agency to focus transparency efforts on "shoppable" health services. These services, such as a caesarean section or a colonoscopy, can typically be scheduled in advance. Based on a 2011 study by the Health Care Cost Institute, 42.5 percent of total spending from employer-sponsored insurance on individuals younger than age 65 was for medical services that can be considered shoppable.[4] Patients in crisis are unable to shop around for the best prices, as medical emergencies require immediate care. We believe that focusing transparency efforts on shoppable services is a more strategic and targeted approach.

Modifications to the Premium Adjustment Percentage

CMS proposes to use average per enrollee private health insurance premiums (excluding Medigap and property and casualty insurance), instead of employer-sponsored insurance premiums, to calculate the premium adjustment percentage for the 2020 benefit year. According to CMS' Office of the Actuary, this would result in net premium increases of approximately $181 million per year and would cause 100,000 people each year to drop their insurance coverage. CMS states, "Some of the 100,000 individuals estimated to not enroll in Exchange coverage as a result of the proposed change in the measure of premium growth used to calculate the premium adjustment percentage may purchase short-term, limited-duration insurance, though a majority is likely to become uninsured. Either transition may result in greater exposure to health care costs, which previous research suggests reduces utilization of health care services."

AHPA recommends that CMS *not* finalize this policy. We believe that this measure will reduce coverage. And while cutting coverage today may reduce health care expenditures in the short-term, this will lead to greater spending in the future. A reduction in health coverage will cause individuals to turn to high cost settings, such as Emergency Departments, for care that could otherwise be received in lower cost settings, such as physician offices. Indeed, research has demonstrated that

[3] Associated Press-NORC Center for Public Affairs Research, Finding Quality Doctors: How Americans Evaluate Provider Quality in the United States.
[4] Frost, A., et. al., Health Care Consumerism: Can the Tail Wag the Dog?

insurance coverage leads to greater access to primary care, more ambulatory care visits and increased use of prescription medications.[5] However, increased utilization of such medications and services, particularly preventive care, has also proven to help maintain or improve health.[6] Without insurance coverage, individuals tend to delay necessary care until they are sicker and need more expensive treatment to seek health care. Having insurance coverage is particularly important for people with chronic conditions, a high-cost population. According to the Centers for Disease Control and Prevention, 90 percent of the nation's $3.3 trillion in annual health care expenditures are for people with chronic and mental health conditions.[7] Preventing or managing the symptoms of chronic disease through accessible primary care and early interventions can significantly reduce these health care costs.

Conclusion

AHPA welcomes the opportunity to further discuss any of the comments provided above. If you have any questions or would like further information, please do not hesitate to contact me at Carlyle.Walton@AdventistHealthPolicy.org or Julie Zaiback-Aldinger, Director of Public Policy and Community Benefit, at Julie.Zaiback@AdventHealth.com.

Sincerely,

Carlyle Walton, FACHE
President
Adventist Health Policy Association

[5] Sommers, B., Gawande, A., Baicker, K., Health Insurance Coverage and Health — What the Recent Evidence Tells Us.
[6] Ibid.
[7] Centers for Disease Control and Prevention, Health and Economic Costs of Chronic Disease.