American College of Physicians
Leading Internal Medicine, Improving Lives

The Honorable Steven Mnuchin
Secretary
United States Department of Treasury
1500 Pennsylvania Ave. NW
Washington, DC 20220

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

December 30, 2020

Re: Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards (CMS-9914-P)

Dear Secretary Mnuchin and Secretary Azar,

Thank you for the opportunity to comment on the Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards proposed rule. The American College of Physicians (ACP) members include 163,000 internal medicine physicians, specialists, and medical students dedicated to scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

FFE, SBE-FP, and State Exchange Direct Enrollment Options

ACP strongly opposes allowing states to engage private sector entities, like web-brokers and insurance agents, to operate an enrollment pathway in place of the centralized Exchange that enables apples-to-apples plan comparisons. We believe this is an unnecessary change that will confuse patients who are used to shopping for and purchasing insurance through the Exchange. Seventy percent of patients shop for and enroll in coverage through Exchanges, so it is apparent that patients prefer the Exchange to private sector Direct Enrollment (DE) or Enhanced Direct Enrollment (EDE) exchanges.

ACP remains concerned that many private non-Exchange entities offer both Qualified Health Plans (QHPs) and non-QHPs, such as short-term limited duration plans, that do not comply with the ACA's consumer protections and insurance regulations. Covert testing performed by the Government Accountability Office found that a substantial number of insurance sales representatives engaged in "potentially deceptive marketing practices" by saying a non-ACA compliant plan covered the caller's pre-existing condition when it did not. Without appropriate safeguards, a DE or EDE entity performing Exchange functions could direct consumers to a plan that does not meet their needs, including one that does not comply with the ban on pre-existing condition exclusions or other protections. In a seven-state study, health insurance brokers reported that they received more compensation for selling short-term plans and other non-ACA-compliant products than ACA-compliant individual market plans. Additionally,

it is unclear whether DE or EDE platforms would furnish decision support tools found on the Exchange, including provider and formulary search functions and the out-of-pocket cost comparison tool.

In the rationale for the proposal, CMS argues that operating an Exchange is "costly and burdensome" and the design results in substantial delays during high-traffic periods. However, there is no guarantee that a private DE or EDE would not face the same financial or operational difficulties. Permitting a state to partner with multiple private DE or EDEs may address these issues, but negates the intent of the Exchange, which is to provide a one-stop shop for accessing plan information in a standardized, user-friendly format.

It is unclear how states would be permitted to select the DE or EDE option without going through the Section 1332 State Innovation waiver process. Georgia submitted a 1332 waiver proposal that sought to require consumers to shop for and enroll in coverage through private web-brokers and insurance agents instead of the Federally-facilitated Exchange. The proposed waiver was highly controversial and went through numerous iterations. The Georgia chapter of ACP opposed the 1332 Georgia Access waiver proposal. We believe that any state seeking to replace the one-stop Exchange with one or more private DE or EDE should have to go through the 1332 waiver process to ensure guardrail requirements are met and the public has an opportunity to comment.

31 CFR Part 33 and 45 CFR Part 155–State Innovation Waivers

ACP opposes codifying the 2018 guidance regarding 1332 State Innovation Waivers. We remain concerned that the 2018 guidance provides too much flexibility to states in meeting the waiver's four statutory guardrails. As a result, states could seek to promote health plans that do not comply with ACA insurance rules and patient protections and/or impose high cost-sharing.

Premium Adjustment Percentage, Maximum Annual Limit on Cost-Sharing

ACP is concerned that the agency continues to use methodologies that result in higher costs for patients. For example, the proposed maximum annual limit on cost-sharing figure will be $9,100 for self-only coverage and $18,200 for non-self-only coverage, a 6.4% increase from 2021. Given the COVID-19 public health emergency and ensuing economic downturn that could last into 2022, we request the agency make changes to lower the out-of-pocket cost ceiling and ensure premiums are affordable.

Thank you for considering our comments. If you have any questions, please contact Ryan Crowley, Senior Associate, Health Policy at rcrowley@acponline.org.

Sincerely,

Jacqueline W. Fincher, MD, MACP
President
American College of Physicians