AMERICAN LUNG ASSOCIATION.

Harold P. Wimmer
National President and
CEO

February 19, 2019

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

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020 (CMS09926-P)

Dear Secretary Azar:

The American Lung Association appreciates the opportunity to submit comments on the proposed rule, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020 (CMS09926-P)."

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 35 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.

In March 2017, the Lung Association committed to a set of healthcare principles (see Appendix A). The principles state that any changes to the healthcare system must achieve healthcare that is affordable, accessible and adequate for patients. Unfortunately, not all provisions in the proposed rule meet this standard, therefore, the Lung Association urges HHS to modify the proposed rule to protect patients.

<u>Increasing Premiums and Out-Of-Pocket Costs</u>
In the 2020 Notice of Benefit and Payment Parameters, HHS proposes to change the methodology to determine the annual premium adjustment percentage. This percentage measures premium growth and has far-reaching implications for the affordability of healthcare across the country. This change will impact lung disease patients and healthcare consumers in a number of different ways.

The methodology change will result in less generous advanced premium tax credits (APTCs). The smaller APTCs will mean fewer patients and families are able to afford health insurance in their state exchange. The options they will be left with are either going without coverage or possibly purchasing a

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skimpy plan. For patients with lung disease, neither option will provide coverage or access to the treatment they need. HHS estimates that the reduction of APTC will result in 100,000 people losing healthcare in 2020.[1] A skimpy plan can choose not to cover a person with a pre-existing condition like asthma or COPD; or might not cover needed life-sustaining treatment. This is unacceptable for patients with lung disease.

The methodology change will also impact the cost of healthcare for all Americans with private insurance. The change in methodology will increase the maximum out of pocket costs (MOOP) allowed for all private insurance enrollees, including those with employer-sponsored coverage. The proposed rule's preamble noted that the MOOP for an individual and family will increase by $200 and $400 respectively in 2020. The Lung Association fears this will lead to more patients forgoing needed care, leading to worse health outcomes and increased costs for the health system.[2] In addition to increased out-of-pocket costs, this methodology change will increase premiums for the 7.3 million people that purchase health insurance coverage in the exchange.

These impacts on the affordability of healthcare coverage will only worsen over time, as the methodology will continue to provide less generous APTCs as the MOOP continues to increase at a faster rate than it would have absent a change in policy. This will lead to hundreds of thousands of Americans losing coverage. For patients with lung disease, this could cause delays in treatment and worse health outcomes.

The American Lung Association opposes this unnecessary change to existing policy and urges HHS to withdraw these changes to the premium adjustment formula. The Lung Association also requests that HHS not take any additional actions that would further increase premium costs for consumers. Premium cost increases are likely to increase the number of people that forego insurance or purchase inadequate coverage.

Direct Enrollment

Currently, the exchanges rely on healthcare.gov to enroll consumers and patients into health insurance plans. Healthcare.gov has specific safeguards built into the system to help ensure patients and consumers choose a plan that is the best financial and coverage option for them. The exchange identifies patients and consumers who are eligible for Medicaid or Medicare and directs them to the appropriate enrollment process. This is a key feature of the exchange, allowing consumers to enroll in the most affordable and medically appropriate plan.

The exchange also calculates a patient's advanced premium tax credit (APTC) and eligibility for a cost sharing reduction (CSR) silver plan. These features allow patients and consumers to accurately compare the cost of the premiums between different plans and metal levels. By knowing the value of the APTC, patients and consumers can purchase the plan that is the best value for them and their healthcare needs.

In the proposed rule, HHS proposes expanding direct enrollment which would allow insurers and web-brokers to enroll consumers in an insurance plan directly. Allowing these entities to enroll

consumers in plans will limit the ability to compare plan price and benefit design and could result in harm to patients or consumers who become enrolled in substandard or inappropriate insurance coverage. This failure to appropriately shield consumers, particularly those with pre-existing conditions, from risk is not acceptable. As such, the Lung Association urges HHS to not finalize this provision of the proposed rule.

Direct enrollment under this proposal would also not require an insurer or web-broker to list out all the plans 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 also 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.

Encouraging direct enrollment will also expose patients and consumers to non-qualified health plans (QHPs) during enrollment - including substandard options such as short-term and association health plans. Currently, every plan sold on the exchange 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, less expensive plans.

Non-comprehensive, skimpy health plans do not cover the services and treatments that lung disease patients need to manage their conditions and, in many cases, stay alive. Any confusion caused by obscuring information consumers need to make informed health care decisions can result in patients not getting the care they need. The Lung Association strongly urges HHS to not include these changes in the final rule.

Prescription Drugs Access

Prescription drugs are an important component of treating many types of lung disease, including lung cancer, asthma and COPD, as well as for helping smokers quit. The Lung Association believes prescription drug coverage should be evaluated on the three principles of affordability, accessibility and adequacy.

The Administration proposes to make a number of changes to requirements around prescription drug benefits. Many of these proposals specifically use generic drugs as a potential method to reduce costs. However, the definition of generic throughout the proposed rule needs to be clarified. First, the Lung Association believes HHS should define generic as an AB-rated generic equivalent medication or an FDA designated interchangeable biosimilar. It is important that patients with lung disease have the treatment they need to breathe. Specifying the need for the AB-rated generic and interchangeable biosimilars will help to ensure lung disease patients have the medications they need. Additionally, the Lung Association strongly encourages HHS to require

issuers to cover the AB-rated generic or interchangeable biosimilar if the proposed policies are finalized.

The Administration is proposing to let issuers who cover a drug with a generic equivalent to either exclude the price difference between the generic and the brand name from the MOOP or to exclude any cost of the brand name towards the MOOP. While the Lung Association appreciates the Administration's goal of reducing drug costs, there are some significant concerns with these proposals and its impact on patients. As described above, the Lung Association is concerned about the lack of definition around generic. The Lung Association also believes this proposal would introduce confusion around prescription drug coverage which could have unintended consequences for patients, including not getting timely treatment and difficulty affording their medications. Issuers already have a lot flexibility on designing their drug coverage. The Lung Association believes all cost-sharing should count towards the MOOP and urges HHS to not adopt this policy.

The Administration is also proposing to allow issuers to make mid-year changes to their formulary if a generic alternative becomes available. Unfortunately, this proposal could also create confusion and not improve affordability for patients and consumers. When enrolling in insurance coverage, consumers are encouraged to verify the medications and treatments they need are covered. Allowing mid-year formulary changes will remove this assurance of coverage for patients. Additionally, there are a number of problems with the proposal as written. If HHS were to go forward with it, generics should be defined as an AB-rated generic or an interchangeable biosimilar. Additionally, any new generic substitution must be placed on a lower cost-sharing tier than the brand name was. This will ensure the cost-savings is shared by both, the issuer and the patients. Lastly, a robust, clearly defined appeals process must be available for patients. Information regarding this appeals process must be included in the required notification to enrollees.

Access to prescription medications is vital for patients to survive and manage their lung disease. The Lung Association urges HHS to not adopt policies that will make it more difficult for patients to afford their needed treatments.

<u>Essential Health Benefits (EHB)</u>
The American Lung Association has grave concerns with the Administration's policy aimed at weakening the EHB requirement in the 2019 Notice of Benefit and Payment Parameter. Last year, the Administration's move to destabilize these core patient protections by allowing states to mix and match benefit structures in a way that could harm patients was particularly worrisome.

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 (AHPs) and short-term plans and new guidance on 1332 waivers, could allow states to loosen patient protections and give them authority to offer not just less generous

coverage, but the *least* generous coverage – jeopardizing the integrity of the ACA and the policies that underpin its quality. The Lung Association reiterates our ask that HHS undo these policies.

Silver Loading

In October of 2017, the Administration, per advice from the Attorney General, stopped funding the cost-sharing reduction payments (CSRs) that section 1402 of the ACA requires insurance companies to provide to low-income marketplace enrollees. As issuers were still required to provide the subsidies to low-income enrollees but no longer received federal funding to pay for them, they increased premiums to cover their costs. The practice of silver loading refers to increasing premiums only for silver plans to cover the cost of CSRs, as oppose to spreading the cost over all individual market plans.

An unexpected but beneficial result of silver loading for consumers has been an increase in the value of advanced premium tax credits (APTC), since the government calculates APTCs using the cost of the second-lowest cost marketplace silver plan. This has made it possible for some consumers to pay less for bronze or gold plans than they would have in years past. Silver loading has also kept premiums of bronze, gold and platinum level plans more affordable than they would have been absent the practice, giving unsubsidized consumers more affordable alternatives.

It is important that HHS allow silver loading to continue unless a broader solution on CSR payments, stabilization and marketplace affordability is reached and current attempts to administratively undermine the ACA cease. Absent silver loading, premiums for all individual market plans will rise and the value of APTCs will fall, exacerbating affordability issues for unsubsidized and subsidized consumers alike and reducing marketplace enrollment.[3] The Lung Association supported marketplace stabilization efforts in the last Congress and will continue to call for renewed efforts on this topic, evaluating any proposal on its potential to improve the affordability, accessibility and adequacy of health insurance for all Americans.

Until there is a permanent solution regarding the CSR payments and the overarching affordability of insurance premiums, our organizations urge the Department to allow silver loading. Our organization believes that by staying consistent and keeping silver loading, the market will be more stable, which will be reflected in premiums. A stable market and insurance premiums that reflect market stability are important for patients, especially those with pre-existing health conditions. Patients need to be able to plan healthcare costs more than 12 months into the future. Most lung disease patients will need treatment for the rest of their lives – it is important that they can plan for their future.

While the Lung Association recognizes the "band-aid" like nature of silver loading, we would strongly encourage HHS to allow silver loading until Congress and the Administration have permanently funded the CSR payments, creating a more stable market. Only then will we support ending silver loading in a gradual and phased manner. This will add to stability in the marketplace and provide more affordable coverage option to many patients.

Auto Renewal

The Administration seeks comment on changing or eliminating the policy to automatically re-enroll consumers who have not chosen a new health plan during open enrollment. In 2018, approximately 25 percent of consumers were automatically renewed in their plan;[4] a total of 1.8 million were re-enrolled for plan year 2019. This safeguard protects consumers who might have missed the open enrollment period. Additionally, it helps keep a stable enrollment in the exchanges, creating premium stability for both consumers and issuers. Ending auto-enrollment would be particularly concerning among older adults, people with low health literacy, and people at lower-income levels. Given the lack of a compelling reason to change the policy, the Lung Association strongly encourages HHS to maintain the policy of auto renewal.

The American Lung Association appreciates the opportunity to submit comments on this important rule and urges HHS to keep patients in the forefront when creating new policies that impact the accessibility, adequacy and affordability of healthcare.

Sincerely,

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National President and CEO

CC: The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services

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[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 227-321 (Jan 24, 2019). https://www.regulations.gov/document?D=CMS-2019-0006-0016

[2] 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.

[3] Anderson D. et al. Implications Of CMS Mandating A Broad Load Of CSR Costs. https://www.healthaffairs.org/do/10.1377/hblog20180511.621080/full/. Accessed February 7, 2019.

[4] Armour S. Trump's Proposed ACA Rules Could Boost Costs for Millions of People. The Wall Street Journal. 2019. Available at https://www.wsj.com/articles/trumps-proposed-aca-rules-could-lift-costs-for-millions-of-people-11547775475?emailToken=774bc4bebc0f134eb1cbdb62929ce275slrMAjxYosOIBrHI2PV0GhknF/RER9

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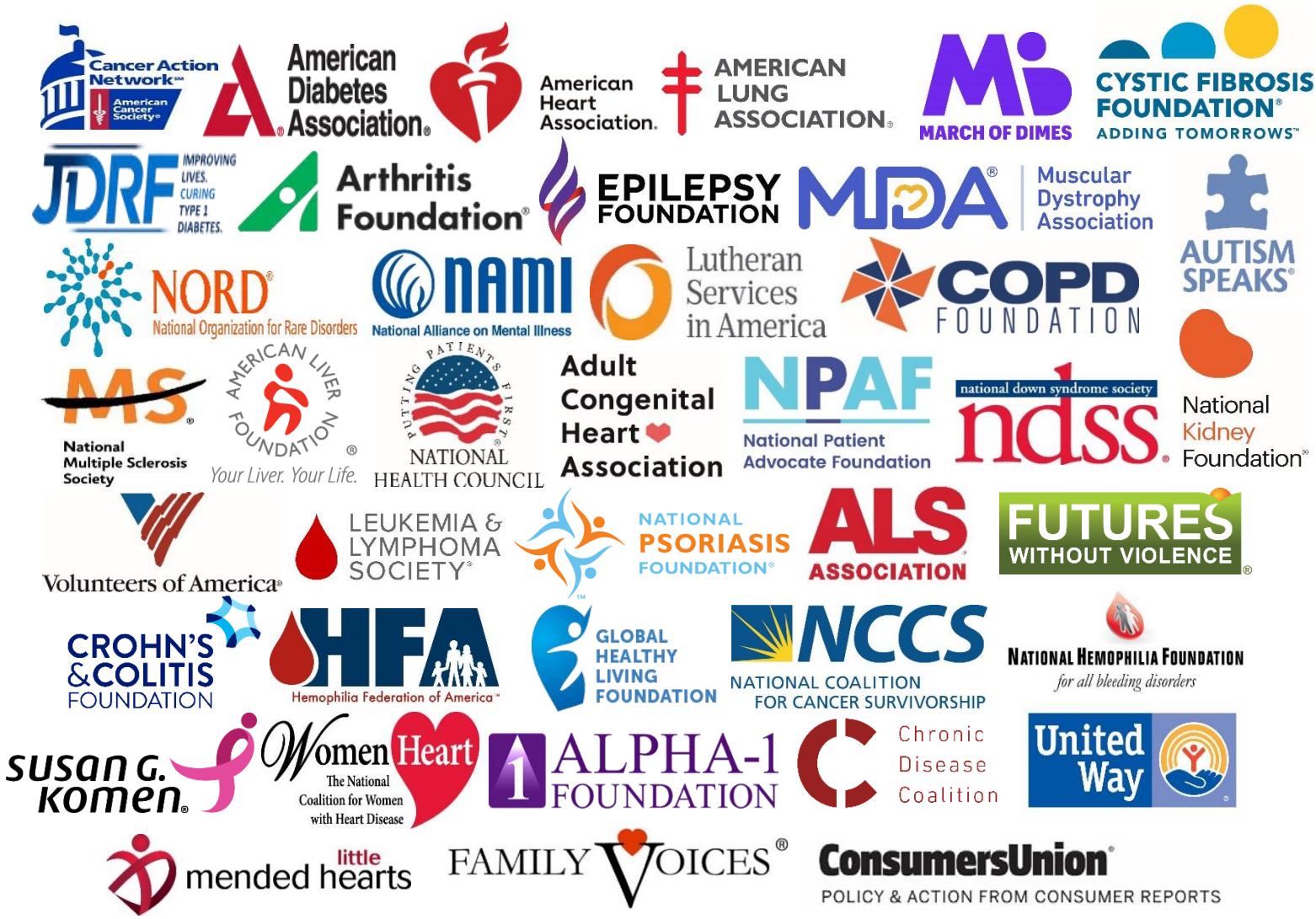
Appendix A



Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all.

In addition, any reform measure must support a health care system that provides affordable, accessible and adequate health care coverage and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

Health Insurance Must be Affordable – Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must be Accessible – All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must be Adequate and Understandable – All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.

Adult Congenital Heart Association
Alpha-1 Foundation
ALS Association
American Cancer Society Cancer Action Network
American Diabetes Association
American Heart Association
American Liver Foundation
American Lung Association
Arthritis Foundation
Autism Speaks
Chronic Disease Coalition
Consumers Union
COPD Foundation
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Futures Without Violence
Global Healthy Living Foundation
Hemophilia Federation of America
Juvenile Diabetes Research Foundation
Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes
Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Coalition for Cancer Survivorship
National Down Syndrome Society
National Health Council
National Hemophilia Foundation
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