AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Information: Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices To Empower Patients (CMS–9928–NC; 82 Fed. Reg. 26885, June 12, 2017)

Dear Administrator Verma:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to offer our comments on the Centers for Medicare & Medicaid Services' (CMS) Request for Information regarding Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients. The AMA appreciates that the Department of Health and Human Services (HHS) and CMS are working to reduce regulatory burdens and improve health insurance options under Title I of the Patient Protection and Affordable Care Act (ACA) and are engaged in efforts to create a more patient-centered health care system that adheres to the key principles of affordability, accessibility, quality, innovation, and empowerment.

Stabilizing the individual, small group, and non-traditional health insurance markets

To promote market stability in the near term, the AMA strongly encourages HHS and CMS to provide health care insurers with the clarity and certainty they need to determine marketplace participation and premium rates for the 2018 plan year. Uncertainty about continued funding for cost-sharing reductions (CSRs) and enforcement of the individual mandate is contributing significantly to market uncertainty and volatility. Nearly 60 percent of all individuals with effectuated marketplace enrollment as of February 2017—5.9 million people—receive assistance to reduce deductibles, co-payments, and/or out-of-pocket limits through CSR payments to insurers. If these subsidy payments cease, it will be considered a breach of contract and insurers would be able to withdraw from the market immediately to avoid financial losses, leaving their enrollees with no coverage. One of the most significant ways that the Administration can help to stabilize the individual market is to commit to funding CSRs for at least the remainder of 2017 and 2018. Cost-sharing subsidies are necessary not only to make health care services affordable for individuals with low incomes, but to stabilize the individual health insurance marketplace.

The individual shared responsibility provision of the ACA has contributed to coverage gains and promotes a balanced risk pool of individuals between those who are sick and those who are healthy. The AMA continues to believe that an individual mandate remains the best way to maximize coverage gains, as well as help ensure healthy individuals enroll in coverage and stay covered. Without dutiful

enforcement of the individual shared responsibility provision, insurers are left without clarity as to what their risk pool in 2018 will look like, which has already impacted 2018 rates that have been submitted. If the individual shared responsibility provision is not enforced, fewer younger and healthier individuals will enroll in health insurance coverage as the provision encourages individuals to get health insurance coverage to avoid paying the individual shared responsibility payment. In addition, as the level of enforcement of the individual shared responsibility provision has already influenced some insurers as they set their 2018 rates, some young, healthy individuals may forego health insurance in response to any resulting higher premiums.

The AMA believes that a consensus approach to stabilize the individual market is to create risk adjustment and reinsurance programs to account for high-risk/high-cost patients enrolled in marketplace plans to protect against premium increases. When compared to high-risk pools, risk adjustment and reinsurance are more efficient uses of government funds to advance affordability and coverage goals. For example, to fund the ACA's transitional reinsurance program, insurers and third-party administrators paid $63 per enrollee per year in 2014, $44 in 2015, and $27 in 2016. These investments in reinsurance yielded premium reductions, and suggest that a permanent reinsurance program may be a desirable policy option, whether administered at the federal or state level. For example, in 2014 the $10 billion reinsurance fund, the result of the $63 per enrollee per year contributions, was estimated to reduce premiums by 10-14 percent. At the same time, high-risk enrollees remained in the same individual market risk pool and enjoyed the same protections as healthy plan enrollees—evidence that reinsurance mechanisms promote greater equity and fairness in terms of coverage provided to individuals with high health care costs. State high-risk pools historically have not been adequately funded, had waiting periods or exclusions for individuals with pre-existing conditions, featured premiums above standard non-group market rates, and commonly included lifetime limits on benefits. The AMA was encouraged by the Administration's recent invitation of section 1332 waiver proposals that include reinsurance, and believes that, absent federal legislation that would establish and provide a funding mechanism for another federal reinsurance program, states can use the current section 1332 waiver framework to improve individual market stability and reduce individual market insurance premiums via reinsurance.

The AMA agrees with the Administration that additional actions are necessary to increase the number of younger and healthier consumers purchasing plans through the marketplaces. Considering the shorter time frame of the upcoming open enrollment period for 2018 coverage, it will be critical for CMS to engage in and dedicate the necessary resources toward extensive outreach and education to ensure that all consumers, including young adults, are informed about the shorter time frame to enroll in coverage and that they understand the consequences of failing to do so during this period. In addition, administrative actions can be taken, or section 1332 waivers could include provisions, to resolve the ACA's "family glitch," which denies premium and cost-sharing subsidies to purchase coverage on health insurance exchanges to families facing high-cost employer-sponsored insurance when one family member has access to affordable employee-only coverage, ignoring the cost of family coverage. A significant percentage of affected employees and their families are under the age of 35. As a result, in addition to providing more individuals and families with access to affordable coverage, fixing the "family glitch" could help balance the individual market risk pools. Also, states, through section 1332 waivers, could provide young adults (ages 19-30) with enhanced tax credits—e.g., $50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio. Smaller amounts could be provided to individuals between ages 30-35. Providing enhanced tax credits to young adults would improve health insurance coverage rates for this population as well as help balance the individual market risk pools.

Enhancing affordability

The AMA has long supported advanceable, refundable tax credits that are inversely related to income as a preferred method for assisting individuals in obtaining private health care coverage. As millions of Americans have enrolled in coverage offered through health insurance marketplaces, progress has been made in covering the uninsured and expanding access to affordable, quality health care. However, for many Americans, premiums and cost-sharing remain too high. Many individuals, particularly those with incomes that qualify for little or no premium subsidization, have difficulty affording their coverage, and premiums for some individuals already eligible for premium tax credits still may be too high to incentivize them to get covered. While those for whom costs exceed a set percentage of income are exempt from penalties for failure to secure coverage, they are nonetheless negatively impacted by their inability to afford coverage. Moreover, we remain concerned that patients enrolled in plans with high deductibles and other cost-sharing requirements may have difficulty affording the care they need, which can result in them avoiding or delaying needed care. There may be roles for innovative benefit designs, as well as the use of health savings accounts (HSAs), to support patients in affording and accessing necessary and timely care.

The AMA believes that there are several steps that HHS and CMS can take to enhance the affordability of coverage for individual consumers and small businesses. As noted above, uncertainty about the continuation of funding for CSRs has not only affected the stability of the individual insurance market, but has also had a negative impact on the affordability of coverage. We urge the Administration to commit to continued funding, at least through the remainder of 2017 and through 2018, to help ensure both affordability of coverage and stability in the market. In addition, as previously mentioned, providing enhanced tax credits to young adults would help with affordability of premiums and encourage such individuals to buy insurance before they become sick, and fixing the family glitch would also help make coverage more affordable.

The AMA believes that another way to address affordability would be to create demonstration projects to provide a pre-funded HSA to individuals with incomes up to 250 percent of the federal poverty level who enroll in bronze plans. The amount of the HSA would be equivalent to the amount they otherwise would have received as a cost-sharing subsidy had they enrolled in a silver plan. Therefore, in cases where individuals forego cost-sharing subsidies by enrolling in a bronze plan, they would have some contributions in their HSAs to help finance the medical care they need. Unspent HSA funds would roll over from year to year, creating greater protection against high deductibles.

The AMA previously provided comments to CMS on the proposed change earlier this year to the de minimus variations allowed in actuarial value (AV), from the current +/-2 to -4/+2 percentage points for the four metal levels of plans offered through the exchanges (except for bronze plans, which could vary from -4 to +5 percentage points). We argued against making these changes because of our concern over higher deductibles and other out-of-pocket costs. Healthy, higher-income individuals might be interested in such plans due to lower premium costs. However, we are concerned that this change would, in turn, reduce the value of the advanced premium tax credits, which are determined based on the second lowest cost silver plan premium. Consumers with moderate incomes would be confronted with higher out-of-pocket costs, either through premiums or cost-sharing. This would mean that for consumers who wanted to keep the same coverage they currently have, tax credits would cover less of the cost. Either way, patients will end up paying higher premiums or opting for worse coverage. By far one of the most frequent complaints we hear from physicians about the ACA is that high out-of-pocket costs discourage

patients from obtaining needed tests and follow-up care, filling prescriptions, etc. This is the same concern we have with the health care insurance reform bills currently being debated in Congress. Accordingly, we urge CMS to reverse the modifications to the de minimus AV variations that were finalized earlier this year.

Ensuring active, meaningful regulation of provider networks is a priority for physicians. Over the past several years there has been a significant narrowing and tiering of provider networks, often resulting in the exclusion of physicians who care for vulnerable patients from networks or accessible tiers. Physicians are concerned that these limited networks are compromising patients' access to quality care. Additionally, narrow networks are increasing patients' out-of-pocket costs by forcing them, knowingly or unknowingly, to go outside of their networks to receive necessary care. Patients deserve to receive value for their premiums paid, and that includes being able to access affordable, quality care when needed.

At a minimum, insurers must provide patients access to:

- A full range of primary, specialty, and subspecialty providers for children and adults providing physical, mental, and behavioral health services;
- All providers in a timely and convenient manner;
- All covered services at the lowest cost-sharing tier;
- Accurate, up-to-date, and easily accessible directories;
- Publicly available information regarding how providers are selected for participation in the networks; and
- Timely, transparent appeal processes for care outside of the network.

To ensure that provider networks are adequate and patients have access to quality care, stronger regulation at the state and federal levels is needed.

Empowering patients and promoting consumer choice

Patients need clear and accurate information about health care plan choices in order to select the plan that best suits their individual needs. Such information should address the following:

- Provider directories: Patients need accurate and up-to-date provider directories to make informed decisions about their health care and health insurance. Patients must be able to assess whether their preferred physicians and hospitals are in network, whether these physicians are accepting new patients, and what the likely wait time is for an appointment. Unfortunately, consumers are often provided erroneous or incomplete information, and find out that their providers are not in their networks or that the network will not meet their needs only when it is too late. In fact, multiple studies have found unacceptable rates of inaccuracy in provider directories across the country (*JAMA* Dermatology, December 2014; California Department of Managed Health Care, November 2014; CMS, January 2017, https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Final_01-13-17.pdf). The impact of inaccurate provider directories on consumers can be devastating, especially on those consumers who need to carefully examine networks for specific subspecialists, cancer centers, or children's hospitals. As such, the AMA encourages the Administration to continue to improve requirements on updates to provider directories and promote meaningful safeguards to protect patients from inaccuracies. Additionally, prospective enrollees should always

be permitted to access directories without required logins or passcodes to review the network prior to purchasing the product.

- Network Breadth: The AMA strongly supports efforts to increase transparency in network breadth for consumers. Restrictive network designs are quickly replacing more robust networks and unanticipated patient costs often result when patients must access care that is outside of the network or beyond the coverage offered by their plan. Too often, patients are not aware of the restrictive nature of their network. Therefore, the AMA suggests that the Administration work with stakeholders to develop a classification system to assist patients in selecting a plan that best meets their needs, focusing on the breadth of the network compared to other plans in the region. Such a system should be conveyed to patients in a clear and concise manner—making it easy for patients to understand. Additionally, such a system should evaluate access to all providers, including primary care providers, specialists and subspecialists, as well as facilities.

- Cost-sharing: The AMA urges stronger patient education during the health plan enrollment process to ensure patients understand the scope of their coverage and are able to base their enrollment decision not solely on the cost of the premium, but rather on all cost-sharing that may be applicable through the year, including co-pays, deductibles, and other co-insurance. Such education should include the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services. With additional education, patients will have a greater understanding of the impact of enrolling in plans with higher deductibles, co-payments, and co-insurance and will be able to make informed decisions about which plans are right for them.

- Prescription drug coverage: Patients, especially those with chronic conditions, must carefully consider a plan's formulary when shopping for health insurance to ensure that their prescription drugs are covered. Unfortunately, formulary documents may often be inaccessible for prospective patients or too generalized for a patient to make an informed decision. Allowing access by prospective and current enrollees to formulary documents is critical to consumer choice, as are clear indications of which formularies apply to which individual product. Additionally, consumers (and physicians) should be able to easily determine any coverage restrictions and utilization management requirements, including tiered co-pays, prior authorizations, and step-therapy, applying to drugs on the formulary. These types of restrictions can greatly impact a patient's costs and access to care, and the use of these tools in a prescription drug benefit should factor into a patient's decisions when purchasing a plan.

The AMA believes that much can be done to improve the opportunities for patients to make informed decisions about their health insurance through effective outreach and assistance during open enrollment. Accordingly, the AMA urges CMS to improve outreach efforts to patients.

Thank you for considering our comments. If you have any questions, please contact Margaret Garikes, Vice President of Federal Affairs, at 202-789-7409 or margaret.garikes@ama-assn.org.

Sincerely,

James L. Madara, MD