AMA
AMERICAN MEDICAL ASSOCIATION

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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: Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2021; Proposed Rule

Dear Administrator Verma:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the Department of Health and Human Services' (HHS) and Centers for Medicare & Medicaid Services' (CMS) Proposed Rule on Notice of Benefit and Payment Parameters (NBPP) for 2021. The AMA provides comments below on the following significant issues: automatic re-enrollment; medical loss ratio; cost-sharing and drug manufacturer coupons; and special enrollment periods (SEPs).

Automatic Re-Enrollment

Under current regulations, enrollees in plans offered through a federally-facilitated exchange or a state-based exchange using the federal platform have several options during open enrollment periods regarding their coverage. They can re-enroll in their current plan, select a new plan, or take no action and be automatically re-enrolled in their current plan. Enrollees have been allowed to re-enroll since the first year of enrollment. In last year's NBPP proposed rule, CMS raised program integrity concerns that the process could result in inaccurate advanced premium tax credits (APTCs) and requested comments on automatic re-enrollment policies with an eye to possible future rulemaking, but made no changes for 2020. The AMA and other stakeholders opposed eliminating auto-reenrollment at the time. In addition, as part of the December 2019 budget bill, Congress directed the HHS Secretary to establish an automatic re-enrollment process for plan year 2021 in the states that use the federally facilitated exchange, i.e., Healthcare.gov.

Despite the aforementioned Congressional directive and uniform stakeholder opposition, and CMS' own acknowledgment that automatic re-enrollment makes enrolling in health insurance more convenient for consumers, CMS now proposes to change the automatic re-enrollment process for individuals who qualify for zero-dollar premium plans as a result of the application of APTCs. Under current rules, such individuals are automatically re-enrolled in the same way as are other enrollees. Under the proposed rule, these consumers would still be re-enrolled in the same plan but without all or some of their APTCs. In other words, even if their income qualifies them for a zero-dollar premium plan, they would be re-enrolled in a plan and must pay either the full premium or some dollar amount greater than zero.

According to CMS, this would encourage those consumers to go to Healthcare.gov next year to update their financial information and receive an updated eligibility determination and then actively enroll or re-enroll in a plan.

**The AMA opposes this proposed change**. As we stated in our comments in response to last year's proposed NBPP rule, we acknowledge that some consumers who are automatically re-enrolled may forego opportunities to review and update their coverage and tax credit eligibility. However, the AMA is more concerned about the negative consequences that would result by re-enrolling consumers—who would otherwise qualify to be automatically re-enrolled with a tax credit that fully covers their premium—without APTCs or with reduced APTCs. CMS' own data shows that for the 2019 plan year, 1.8 million consumers were automatically re-enrolled, including approximately 270,000 who had zero premiums after tax credits. Many of these individuals have been automatically re-enrolling with zero-dollar premiums for several years, and faced with a hefty premium bill, they may not renew their plan and might end up with no coverage at all. We do not think that this change is consistent with Congressional intent behind the budget provision in requiring HHS to continue auto-re-enrolling any consumer with 2020 coverage into a 2021 plan. In addition, reducing bureaucratic obstacles to re-enrollment can help maintain a stable risk pool and thereby lower premiums and prevent gaps in coverage and care. **The AMA urges CMS to reconsider this proposed change to automatic re-enrollment for low-income exchange enrollees.**

Cost-Sharing and Drug Manufacturer Coupons

The AMA is concerned that CMS' proposed change on increased flexibility for insurers on the use of drug manufacturers' coupons and consumer out-of-pocket limits will result in increased costs to patients. Many patients rely on manufacturers' coupons to help them afford their medications. Under the proposed change, insurers could, but would not be required to, include coupons and other direct support from drug manufacturers towards an enrollee's annual limit on out-of-pocket costs. This would apply regardless of whether the coupon is for a brand drug, and if so, regardless of whether there is or is not a generic equivalent. At the same time, CMS encourages insurers to disclose to enrollees and prospective enrollees the use of accumulator adjustment programs on websites, brochures, plan documents, and other related materials.

The AMA supports economic assistance, including coupons and other discounts, for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured. CMS' proposed change means that consumers would pay more for their medications out of their own pockets, and it will take them longer to meet their deductible and out-of-pocket cap. This result seems inconsistent with the President's priority of reducing the cost of drugs for patients. When the co-pay coupon expires or runs out, or the patient exhausts all other forms of co-pay assistance, the patient is faced with a sudden—and often massive—increase in financial responsibility for a drug, as the coupons have not counted toward his/her deductible. This could result in some patients deciding not to take or continue taking their medications with severe adverse health consequences. **We urge CMS to reverse this proposal; if CMS finalizes it, we urge CMS to require, instead of encouraging, insurers to prominently and clearly disclose to consumers their drug coupon policies so that they understand their out-of-pocket liability under their plans.**

Medical Loss Ratio (MLR)

CMS proposes that for purposes of the MLR, health plans would be required to count drug rebates and price concessions retained by pharmacy benefit managers (PBMs) as administrative expenses. The Affordable Care Act requires all health insurers offering individual or group health insurance coverage—except for self-insured plans—to meet MLR standards. Insurers must spend 80 percent of their premium revenue in the individual and small group market and 85 percent in the large group market on health care claims or health care quality improvement expenses. If insurers fail to meet the required MLR standard, they must provide a rebate to their enrollees. CMS now proposes that insurers would be required to deduct prescription drug rebates and other drug-related price concessions (e.g., manufacturer rebates, remuneration, or an incentive payment) received and retained by PBMs. CMS estimates that this change could result in $18.4 million more per year in MLR rebate payments to enrollees. **The AMA agrees with CMS that this proposed change would prevent PBMs that retain some or all of a rebate from depriving enrollees of benefits and inflating insurers' incurred claims and MLRs. The AMA supports this proposal and urges CMS to retain it in the final rule.**

Special Enrollment Periods (SEPs)

CMS proposes changes to its rules on SEPs. Under current regulations, consumers who lose their eligibility for cost-sharing reductions (CSRs) and are enrolled in an exchange silver level plan are not eligible to switch to a plan at a different metal tier. Instead, such enrollees must choose a different silver level plan, but often are unable to afford the cost-sharing without the CSRs. CMS now proposes to allow such enrollees (and their dependents) that become newly ineligible for CSRs to use an SEP to switch to a bronze or gold plan from a silver plan. CMS also proposes a new SEP for individuals with dependents where the dependent is an exchange enrollee, but the individual is not. For example, this would allow a mother with self-only employment-based coverage who loses such coverage to be added to her children's exchange coverage. **The AMA supports these proposed changes and urges CMS to retain them in the final rule.**

The AMA appreciates your consideration of our comments. If you have any questions, please feel free to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

James L. Madara, MD