AMA
AMERICAN MEDICAL ASSOCIATION

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December 21, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable David J. Kautter
Assistant Secretary for Tax Policy
U.S. Department of Treasury
1500 Pennsylvania Avenue, NW
Room 3120
Washington, DC 20220

Re: State Relief and Empowerment Waivers (CMS-9936-NC)

Dear Administrator Verma and Assistant Secretary Kautter:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the new Guidance relating to State Relief and Empowerment Waivers (previously called state innovation waivers) under section 1332 of the Patient Protection and Affordable Care Act (ACA) issued on October 22, 2018 by the Centers for Medicare & Medicaid Services (CMS) and the Department of Treasury (Treasury) (collectively, the Departments) and published in the Federal Register on October 24, 2018. The new Guidance, effective on October 22, 2018, replaces earlier guidance issued in 2015.

The AMA shares the goals of the Departments to make coverage more affordable for individuals seeking health insurance in the individual and small group markets. We look forward to continuing to work with your Departments toward this goal. However, while there are aspects of the new Guidance that could result in increased affordability for some consumers, we are concerned that this would occur at the expense of vulnerable populations, and at the expense of the availability of comprehensive coverage. Increased affordability could be in name only if people end up with coverage with limited benefits with no true protections for pre-existing conditions and out-of-pocket costs.

We are deeply concerned, for the reasons discussed in further detail below, that the Guidance, in conjunction with the "Waiver Concepts" subsequently released by CMS, will make it easier for states to sidestep important ACA coverage requirements; undercut crucial state and federal patient protections, especially for individuals with pre-existing conditions; result in substandard, inadequate health insurance coverage; and disrupt and destabilize the individual health insurance markets. Most significantly, under the Departments' Guidance, states could use federal funds to subsidize non-ACA compliant plans, including short-term limited duration insurance (STLDI), which would have skimpy benefits and fewer protections for individuals with pre-existing conditions. We believe that these changes are contrary to both the statutory text and congressional intent. Moreover, the AMA believes that there are serious questions about whether the policy changes proposed by the Departments can legitimately be made through informal guidance rather than through a full rulemaking process. Accordingly, we urge that the Departments withdraw the Guidance and reconsider its far-reaching implications for consumers and other stakeholders.

The Departments' Guidance is Inconsistent with Section 1332's Guardrails

Section 1332 of the ACA established a new waiver supporting state innovation to enable states to experiment with and implement different models to provide health insurance coverage to their residents. It allows some of the ACA's private insurance and coverage provisions to be waived, including those pertaining to standards for health insurance marketplaces and qualified health plan standards, premium tax credits and cost-sharing reductions for plans offered through the marketplaces, and the individual and employer mandates. However, states cannot waive key ACA protections, including the ban on preexisting condition exclusions, underwriting based on health status, and the ban on annual and lifetime limits. Under Section 1332, the Secretaries of HHS and the Treasury are authorized to approve a request for a Section 1332 waiver only if the proposal meets the following four criteria or guardrails:

- "Provide coverage that is at least as comprehensive as the coverage defined in Section 1302(b) [e.g., the essential health benefits] and offered through Exchanges…;"
- "Provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;"
- "Provide coverage to at least a comparable number of its residents as the provisions of this title would provide;" and
- "Not increase the federal deficit."

The statutory text is clear that coverage provided under a state waiver must meet all four guardrails. However, the new Guidance looks at the guardrails separately, reinterpreting key phrases in the guardrails to allow the Departments' conclusion that waivers could be approved even if only some coverage under the waiver is as comprehensive, as available, and as affordable as covered provided under the ACA. The Guidance creates new, less restrictive standards for evaluating whether waivers might meet the statutory guardrails, which we believe would have significant negative consequences for many patients. We believe that these changes are contrary to both the statutory text and intent.

For example, "coverage" is significantly re-defined: states will no longer be required to ensure that waivers include minimum essential coverage under the ACA. Instead, coverage is interpreted to be either minimum essential coverage or "health insurance coverage" as defined in 45 C.F.R 144.103, which includes not only individual and group health insurance, but also, non-ACA compliant plans, including STLDI plans and association health plans (AHPs). In fact, the Administration has indicated it would consider favorably state proposals promoting STLDI plans and AHPs, neither of which meet ACA's comprehensive benefit standards or include all ACA pre-existing condition protections. Moreover, the Administration has also stated that states can use the 1332 process to take ACA subsidies that are now helping low- and moderate-income individuals afford ACA-compliant marketplace plans and use it to help individuals to purchase STLDI plans and AHPs.

In addition, under the new Guidance, the Departments have created a troubling new standard for ensuring that coverage is available to a "comparable" number of individuals. Instead of focusing on the actual coverage purchased under the waiver, the focus will be on whether residents have access to comprehensive and affordable coverage, even if they do not actually enroll in this coverage. Further, a state would be able to count people covered under STLDI plans and AHPs as having coverage to meet the coverage guardrail, even though such plans do not meet the comprehensiveness of coverage guardrail.

Under this new access standard, it appears that states can seek a waiver to provide access to less comprehensive or less affordable coverage compared to the ACA as long as ACA coverage is still available to individuals who want to maintain such coverage.

The AMA is very troubled by these changes, and has previously submitted extensive comments to the Departments expressing our opposition to and concerns with the proposed rules encouraging the expansion of STLDI and AHPs. Unlike ACA-compliant plans, short-term plans can exclude coverage of any care related to a pre-existing condition, and can deny coverage or charge higher premiums based on pre-existing conditions or an individual's health status. Both STLDI plans and AHPs can charge higher rates to older people, and neither type of plan must cover the ACA's essential health benefits. However, such plans may be more attractive to younger and healthier people—who do not anticipate having to access health care services—if they offer lower premiums. They can therefore lure away healthy consumers, thereby damaging the risk pool and driving up premiums for consumers purchasing coverage in the ACA-compliant market. We do not believe such plans are consistent with the intent or the text of Section 1332, and we do not support the Administration promoting plans—using federally-funded tax subsidies—that lack the ACA's pre-existing condition protections and may not offer meaningful coverage.

With respect to the comprehensiveness and affordability guardrail, the AMA is concerned that the new Guidance will no longer focus on vulnerable populations, e.g., those who are low-income, elderly, or with chronic conditions or complex health care needs. The 2015 guidance required a separate evaluation of the effect of waivers on vulnerable populations, and states had to demonstrate that such vulnerable populations would not be any worse off due to the waiver under the guardrails related to coverage enrollment, affordability, and comprehensiveness. The new Guidance eliminates these requirements, and instead indicates that the effect of waivers will be assessed in the aggregate and over the entire term of the waiver, rather than each year. Under the Administration's interpretation, a waiver might not be denied because it would have a negative impact on a vulnerable population within a state, or might not meet the guardrails in each year of the waiver. In addition, states will no longer have to show that their waiver proposals would not reduce the number of people enrolled in coverage providing the ACA's required essential health benefits (EHBs) or with coverage of any of the individual EHB categories, such as mental health care, maternity coverage, or habilitative or rehabilitative services. Instead, states will just have to demonstrate that they meet the new access standard discussed above, i.e., that comprehensive coverage is available and that at least as many people will have access to such comprehensive coverage, even if fewer people enroll in it. The AMA is also concerned about the change to the meaning of "comprehensive" under the new Guidance, which is linked to previous EHB changes made by CMS that could result in fewer benefits being covered by many plans.

Another concern we have is with respect to the changes in the Departments' interpretation of the affordability guardrail. Under the 2015 guidance, waiver proposals had to show that there would not be a decrease in the number of individuals enrolled in coverage that capped annual out-of-pocket costs and that was at least as comprehensive as a bronze plan. Under the new Guidance, these requirements have been removed, and instead, a waiver could meet the affordability standard if it makes coverage much more affordable for some and only slightly costlier for a larger number of people. In addition, the access standard discussed earlier will be applied, i.e., whether affordable coverage would be available to as many

people as would have been available without the waiver, regardless of the coverage in which people enroll.

The AMA is very concerned about the potential impact of the new Guidance in destabilizing the ACA marketplace and in increasing the number of people with less comprehensive coverage, and fewer protections for pre-existing conditions and against annual and lifetime limits, and out-of-pocket expenses. The AMA strongly believes that an important federal role remains to ensure that proposals to foster competition in health insurance also promote ACA marketplace stability and a balanced risk pool, and do not lead to adverse selection in the marketplace. Consideration should be given to not dividing the individual market between healthier consumers being drawn to skimpier plans, and individuals with high health needs being drawn to plans following ACA requirements and offering more comprehensive coverage. Such a division in the market could result in rising—in some cases, unaffordable—premiums for those individuals who need and want to buy more comprehensive coverage that is ACA-compliant.

The Administration Has Exceeded its Authority in Issuing its Reinterpretation of Section 1332 as "Guidance"

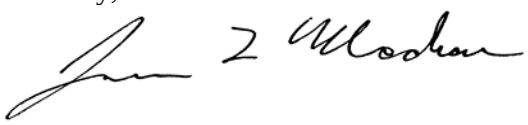
The AMA believes that the reinterpretation of Section 1332 as issued in the Guidance not only is inconsistent with the clear statutory text, but also violates the Administrative Procedure Act (APA). By making such significant policy changes through immediately effective guidance, rather than a full rulemaking process, the Administration appears to consider the Guidance to be an interpretive rule that is exempt from the APA's notice and comment requirements, rather than a legislative rule which would require formal rulemaking. For both substantive and procedural reasons, the AMA urges the Departments to withdraw this Guidance.

Conclusion

The AMA strongly believes that the coverage gains of the past decade should be maintained. Central to this principle is ensuring meaningful coverage, assisting individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations, and ensuring the continuation of essential health benefit categories and their associated protections against annual and lifetime limits and out-of-pocket expenses. Affordability is also critical with regard to lower premiums and out-of-pocket costs as well, which determine the ability of patients to afford health care services when they need them. Such affordability is accomplished by ensuring a stable individual health insurance market and through a level playing field for all health insurers. The Guidance fails to comply with these important principles, and in fact, we believe would reverse progress that has been made in expanding meaningful coverage to millions of previously uninsured Americans. While the AMA supports encouraging state innovation, we do not support innovation that would undercut the important patient protections provided under current law.

Thank you for considering the AMA's concerns about the Guidance. If you have any questions, please contact Margaret Garikes, Vice President for Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,



James L. Madara, MD