American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

December 30, 2020

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

CMS-9914-P

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations

Dear Administrator Verma:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the proposed 2022 Notice of Benefit and Payment Parameters (NBPP). Specifically, we would like to address a few policies proposed in the NBPP that have a significant impact on the coverage of emergency services and access to care for higher risk populations.

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States' EHB-benchmark Plan Options

In previous NBPPs, the Centers for Medicare & Medicaid Services (CMS) had finalized and reiterated the following options for states to select new essential health benefit (EHB)-benchmark plans starting with the 2020 benefit year:

1) Selecting the EHB-benchmark plan that another state used for the 2017 plan year;
2) Replacing one or more EHB categories of benefits in its EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or,
3) Otherwise selecting a set of benefits that would become the state's EHB-benchmark.

Although these changes are now final, ACEP continues to strongly oppose them. Each state has its own unique market conditions, and the Affordable Care Act's (ACA's) benchmark plan provisions have ensured that states can have a package of essential health benefits suited to its needs, while ensuring a floor of minimum coverage requirements. As a result of this additional flexibility now granted to states, the items and services covered within a category can vary significantly from state to state. Allowing a state to use the EHB-benchmark plan of any other state, and even allowing the mixing and matching of a particular category or categories and the benefits included within them from different states' benchmark plans, will quickly result in a race towards the bottom of states picking and choosing amongst the skimpiest offerings to design their own minimal coverage standard. States will be able

to circumvent state benefit mandates and consumers can be left with a narrow set of benefits that do not ensure them access to the items and services they need to manage their health conditions. This will leave them paying even more out of pocket. Since these final changes could limit access to services and drive up costs for consumers, CMS should carefully monitor how states are modifying their EHB-benchmark plans and be prepared to revert back to the stronger requirements.

In this year's NBPP, CMS is seeking comment on setting the EHB-benchmark plan submission deadline for 2023 plan year at May 6, 2022. CMS had previously moved up the EHB-benchmark plan submission deadlines for both the 2021 and 2022 plan years. Given the amount of flexibility states have in setting their EHB-benchmark plans, ACEP urges CMS to require states to provide a significant amount of time for the public to comment on any changes that states are planning to make to their plans.

Establish Exchange Direct Enrollment Options

The Department of Health and Human Services (HHS) proposes an alternative approach to enrolling consumers in qualified health plans (QHPs). Rather than using a centralized, Exchange-run website, certain states could choose to use a "direct enrollment approach," which would rely on private sector entities that establish their own independent websites. HHS does lay out how states that choose this option would still fulfill all the statutory and regulatory requirements, including ensuring that consumers are properly enrolled in QHPs and have access to advanced premium tax credits (APTCs) and cost-sharing reductions (CSRs) if they are eligible to receive these subsidies. Nevertheless, ACEP still has significant concerns with moving away from a centralized, Exchange-run website owned and operated by the government that consumers can trust and know for sure that they are purchasing health care coverage that meets all ACA requirements. This approach also increases the risk that consumers mistakenly purchase less comprehensive and potentially more expensive health care coverage from non-sanctioned private websites. Doing so could put these consumers' health in jeopardy while putting them in financial peril at the same time. **Given the critical importance of ensuring that all consumers are enrolled in affordable, comprehensive health plans that meet their needs, we oppose this proposal and request that HHS not finalize it.**

However, if HHS decides to finalize this approach, we strongly believe that the Department will need to put into place a robust educational campaign to ensure that consumers understand that these private websites must offer the same plans that the public Exchange website does and that everyone who is eligible to receive federal subsidies still has access to them. Further, HHS and/or individual states that decide to pursue this alternative must implement fraud and abuse programs that will immediately crack down on any private websites that mislead consumers by claiming to be enrolling them in QHPs and offering them federal subsidies but are in fact are not doing so.

Section 1332 Application, Monitoring and Compliance, and Periodic Evaluations

In the NBPP, HHS and the Department of the Treasury (the Departments) are proposing to codify previous ACA section 1332 guidance.[1] ACEP would like to reiterate our previous concerns about this guidance.[2] We strongly believe that the Departments push to allow states to pursue "State Relief and Empowerment Waivers" will create more instability in the market and make it more difficult for vulnerable populations to access care. We have significant concerns with the promotion of Association Health Plans and short-term, limited-duration plans as viable alternatives to ACA Exchange plans. Expanding the availability of these plans will lead to an exodus of healthy people from the healthcare marketplace, thereby distorting the market's risk pool. Such a shock to the market could cause plans in the

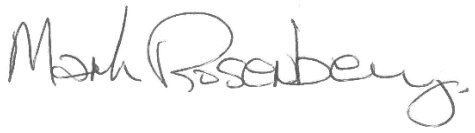
[1] State Relief and Empowerment Waivers Guidance. 83 FR 53575. (October 24, 2018)
[2] ACEP's comments can be found at: https://www.acep.org/globalassets/new-pdfs/advocacy/acep-comments-on-state-relief-and-empowerment-waiver-guidance.pdf.

market to increase premiums, provide less generous benefit packages, or leave the market altogether. Thus, some people who remain in comprehensive plans could also eventually have trouble accessing preventive and other types of services that would prevent them from having to make unavoidable visits to the emergency department (ED).

Furthermore, both Association Health Plans and short-term, limited-duration plans are not required to cover all ten EHBs. We believe that it is critically important for all insurance plans to cover all ten EHBs. Without such guaranteed coverage, consumers can be left with a narrow set of benefits that do not ensure access to the items and services they need to manage their health conditions. Consumers who purchase less comprehensive health plans may wind up deferring more routine care or visiting a primary care physician or specialist for more minor conditions or symptoms. Such deferral or delay will often result in their condition or symptoms becoming exacerbated and eventually, result in a trip to the ED. At this point, due to the progression of their condition, their care in the ED will be much costlier and more complex than if they had earlier access to more routine care in a physician's office.

We appreciate the opportunity to share our comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory Affairs at jdavis@acep.org.

Sincerely,



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