

December 21, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8010
Baltimore, MD 21244-1810

Re: CMS-9936-NC

Re: State Relief and Empowerment Waivers

Dear Administrator Verma:

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On behalf of nearly 38,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on guidance and concepts related to state waivers authorized by Section 1332 of the Affordable Care Act (ACA), as they affect our practice of emergency medicine and the patients we serve.

Over the last several months, the Centers for Medicare & Medicaid Services (CMS) has provided guidance and articulated concepts related to Section 1332 waivers (now known as State Relief and Empowerment Waivers). Specifically, CMS and the Department of Treasury released guidance to states on October 22, and then CMS followed up with a fact sheet outlining four waiver concepts on November 29. ACEP appreciates that the guidance and concepts are meant to give states more flexibility to offer additional health care insurance options to consumers. We support the goal of increasing access to affordable health insurance. However, we are concerned with the impact that the guidance and concepts will have on the coverage of emergency services and access to care for higher risk populations. **We ask the Trump Administration to rescind both the guidance and the concepts immediately for the reasons outlined below.**

State Relief and Empowerment Waiver Guidance

In the guidance released on October 22, CMS and the Department of Treasury re-examines previous guidance released in 2015 related to the four established “guardrails” for Section 1332 waivers. Under these guardrails, state plans will only be approved if they: 1) Provide coverage that it is at least as comprehensive as coverage offered through the ACA Exchanges established by title I of the ACA; (2) Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided under Title I of the ACA; (3) Provide coverage to at least a comparable number of the state's residents as would be provided under Title I of ACA; and (4) Not increase the federal deficit. The 2015 guidance stated that CMS, when reviewing a state plan, would need to determine that

residents would actually purchase coverage that is comprehensive and affordable. It also specified that the number of people projected to have comprehensive and affordable coverage under the waiver could not be less than the number with coverage absent the waiver.

In the revised guidance, CMS and the Department of Treasury now state that a successful state waiver would only need to show that the state would make comprehensive and affordable health plans available to at least a comparable number of people as would have had access to such coverage absent the waiver. As long as the state makes these plans available, the state could also allow health insurers to offer less comprehensive and affordable plans to consumers. New waivers will be evaluated by counting the number of people who would be enrolled in *any* type of coverage, not just comprehensive and affordable plans. Furthermore, in contrast to the 2015 guidance, which required a separate analysis of the effects of the waiver on high-risk and vulnerable populations, the new guidance requires only that CMS examine the effects of the waiver on the population overall. Finally, the guidance provides more flexibility to states regarding the comprehensiveness standard. Instead of comparing comprehensiveness to the benchmark Essential Health Benefit (EHB) plan states use, state waivers could be evaluated against another state's plan that could be less comprehensive.

Concerns with Regulatory Process

ACEP believes that the guidance violates the intent of the important guardrails that Section 1332 of the ACA established. In our view, the guardrails are meant to ensure that all the coverage that is offered under a successful state waiver would have to be comprehensive and affordable—not just some of the health care plans that are available in the state. While ACEP cannot comment on the legality of this guidance, we do believe that the changes included in the guidance are significant enough that they should have gone through formal rulemaking to give the public the proper opportunity to provide comments before the changes were finalized. Although CMS is seeking comments now, the guidance has already taken effect. **ACEP therefore believes that the guidance should be immediately rescinded, and CMS should instead undergo rulemaking to make any such changes to Section 1332 waiver requirements.**

ACEP is also concerned that CMS would be allowing states to apply for waivers without going through a proper authorization and oversight process. Historically, states have been required to enact or amend laws to apply for Section 1332 waivers. However, to provide more flexibility, CMS will now consider state plans as long as the state: 1) already has a law in place that authorizes the state to enforce the ACA or develop a 1332 waiver and 2) has a duly-enacted regulation or executive order authorizing the waiver. Thus, states can apply for a waiver that would have a significant impact on the health insurance market without getting formal approval from the state legislature through a new or modified law. ACEP does not believe it is appropriate for states to rely on existing laws and executive orders to apply for a 1332 waiver and thinks that states should continue the current process of first enacting legislation to ensure that the waivers are vetted and receive the necessary input from stakeholders across the state.

Concerns with Impact on Patient Care

In addition to our process concerns highlighted above, we believe that the guidance, as written, would cause people to lose access to viable, comprehensive insurance options and start to overly rely on the emergency care safety net. This would increase costs in our health care system and put more strain on our already overburdened emergency departments (EDs). In the guidance, CMS specifically supports the diffusion of Association Health Plans and short-term, limited-duration plans. These plans are cheaper and usually attract healthier and less costly consumers since these individuals can withstand being in a plan that does not provide a comprehensive benefit package. Expanding the availability of these plans will therefore 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 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 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.

With respect to short-term limited-duration plans specifically, ACEP understands that these plans typically cover some EHBs, such as ambulatory patient services, emergency services, and hospitalizations. However, a Kaiser Family Foundation study, which examined 24 distinct short-term products offered across 45 states and the District of Columbia, found that on average, only 57 percent of these plans cover mental health treatment and 38 percent cover substance abuse services.¹ There is a severe shortage of mental health resources in the United States, and as a result EDs are seeing significant increases in mental health-related visits. In 2015, about 2.1 million ED visits were seen by a mental health provider, and for about 1.5 million ED visits, the result was admission to the mental health unit of a hospital.² EDs face increasing wait times and crowded conditions due to a lack of hospital inpatient beds, a growing elderly population and nationwide shortages of nurses, physicians, and support staff. If individuals can join short-term health plans that do not cover mental health and substance abuse treatment for longer periods of time, this growing problem could be significantly exacerbated, and lead to a crisis point in EDs across the country.

There are some other aspects of the guidance that ACEP finds particularly concerning. As stated above, the revised definition of comprehensiveness would count the number of people with insurance without measuring the affordability or comprehensiveness of coverage that they would actually have under the waiver. Therefore, while it would be possible for a waiver to cover more residents than would have been covered absent the waiver, the majority of residents could be enrolled in cheaper, less comprehensive, and often less adequate policies at the expense of residents with costly pre-existing conditions who would not be able to afford more comprehensive plans. In addition, the guidance eliminates the requirement that the state show that coverage under a waiver would not be reduced or made less comprehensive or affordable for vulnerable populations. This modification to the previous guidance will make it even more difficult for people who need care the most to purchase affordable coverage. Finally, we are concerned with the additional flexibility states are being provided to select their EHB benchmark plan. Allowing a state to use the EHB benchmark plan of any other state 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

¹ Pollitz, Karen, et al. "Understanding Short-Term Limited Duration Health Insurance." Kaiser Family Foundation, 23 Apr. 2018, www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

² "National Hospital Ambulatory Medical Care Survey: 2015 Emergency Department Summary Tables" Centers for Disease Control, 2015, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf.

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.

Fact Sheet Outlining Four Waiver Concepts

On November 29, CMS outlined four waiver concepts that states can use to take advantage of the additional flexibilities provided in the guidance. These new waiver concepts are:

1. **Account-Based Subsidies:** Under this waiver concept, a state can direct federal subsidies into a defined-contribution, consumer-directed account that a consumer can use to pay for health care premiums and out-of-pocket expenses. The account could also include contributions from employers and the consumers themselves. The goal of this new concept is to give consumers more choices and require them to take responsibility for managing their health care spending.
2. **State-Specific Premium Assistance:** States would be able to create a new, state-administered subsidy program that meets the unique needs of its population. Under this concept, states could provide more affordable health care options to a wider range of individuals and attract more young and healthy consumers into their market.
3. **Adjusted Plan Options:** States would be able to provide financial assistance for different types of health insurance plans, including non-Qualified Health Plans, potentially increasing consumer choice and making coverage more affordable for individuals. States would also be encouraged to use this option in conjunction with the Account-based Subsidy concept so that they could contribute state subsidies to the consumer-directed accounts.
4. **Risk Stabilization Strategies:** This waiver concept gives states more flexibility to implement reinsurance programs or high-risk pools in order to “address the costs of high risk individuals” and potentially reduce premiums in the market for all.

These new concepts, especially the first three, make it easier for consumers to purchase less comprehensive and affordable plans, thereby further exacerbating our concerns about access to care articulated above. By allowing states to use federal subsidies for new consumer-directed accounts and to provide financial assistance for purchasing non-Qualified Health Plans, the market’s risk pool will become even more segmented. Healthier individuals will choose to use the consumer-directed accounts to purchase high-deductible catastrophic plans, thereby driving up premiums and making coverage unaffordable for sicker individuals with pre-existing conditions who purchase more comprehensive plans that comply with the ACA requirements. Furthermore, many people, especially those with pre-existing conditions, rely on federal subsidies to afford comprehensive coverage. Allowing federal subsidies to be diverted to other uses will limit the resources available to these individuals to cover their premiums, likely forcing some of them to drop coverage altogether. **Given these concerns, we ask CMS to also rescind these options or at least provide clarifying guidance about how CMS would ensure that those with pre-existing conditions would still maintain full access to affordable and comprehensive insurance options.**

Overall, ACEP believes that both the guidance and the waiver concepts leave the door open for states to impose drastic changes to the health care market, with little accountability and oversight. These changes to the market

could help some, but likely they would only benefit healthier individuals who are not high users of health care services. High-risk populations with pre-existing conditions would be priced out of the market, causing them to delay care and wind up in the ED if they get sick. **ACEP fundamentally opposes any policies that would create more instability in the market and make it more difficult for vulnerable populations to access care. Therefore, we ask the Administration again to rescind these changes and re-instate the 2015 guidance.**

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,

A handwritten signature in black ink, appearing to read "Vidor E. Friedman". The signature is fluid and cursive, with a large, sweeping loop at the end.

Vidor E. Friedman, MD, FACEP
ACEP President