America's Health Insurance Plans
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December 20, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9936-NC
P.O. Box 8010
Baltimore, MD 21244-1810

Submitted online to www.regulations.gov

RE: State Relief and Empowerment Waivers

Dear Administrator Verma:

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide comments on the guidance on State Relief and Empowerment Waivers, published in the *Federal Register* on October 24, 2018.

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. Based on this mission, we evaluate proposed public policy changes to the health care system by asking how the changes will reduce costs, improve consumer satisfaction, and provide better value and health outcomes for everyone.

Americans deserve a stable, competitive individual market to ensure those who buy their own coverage have access to affordable, quality coverage. Stable and well-functioning insurance markets require broad-based enrollment and a stable regulatory environment that facilitates fair competition and a level playing field. We must continue to strengthen the private market's ability to offer the American people affordable, high-quality health care.

We support federal policies that recognize the role of state regulators, and that provide flexibility for states to implement solutions to improve their insurance markets. Individual and small group coverage pays for the health care people receive where they live and work. For this reason, state policymakers and regulators are best positioned to develop and implement policies that will reduce costs, increase the availability of comprehensive coverage and provide for better health outcomes for state residents.

We appreciate Centers for Medicare and Medicaid Services' (CMS) actions to make it easier for states to address issues in the individual insurance markets with 1332 waivers. We particularly appreciate CMS' work to streamline the application and approval process for 1332 waivers to implement reinsurance programs. The state reinsurance waivers CMS approved in 2017 and 2018 will help thousands more Americans afford their coverage in 2019 and the years to come.

While we support state flexibility generally, we are concerned about the suggestion in the guidance that pass through funding might be made available to subsidize the purchase of products that do not qualify as individual market health insurance under federal law. We describe those concerns in detail in the attachment.

It is impossible to anticipate every waiver application that might be submitted under the new guidance. We will not attempt to anticipate and comment on every possible state proposal in this letter. We look forward to working with state policymakers, stakeholders, and CMS to evaluate each state application on its merits.

Our input on the new guidance is summarized at a high level below. We provide more detail on these points in an attachment:

- We support CMS' emphasis on waiver applications that promote choice, competition, and multiple options for consumers.

- We recommend that pass through funding should not be available to subsidize the purchase of alternatives to individual market health insurance, such as short-term limited duration insurance.

- We support additional flexibility for how states submit enacted legislation with a waiver application, and we offer input on how this option should be exercised.

- We recommend that CMS reissue the guidance through formal rulemaking.

We appreciate the opportunity to provide comments and look forward to working with states and CMS to improve the individual and small group insurance markets.

Sincerely,

Keith Fontenot
Executive Vice President, Policy and Strategy

ATTACHMENT
Detailed Comments

I. Promoting Choice and Competition

We support CMS' emphasis on waiver applications that promote choice, competition and multiple options for consumers. Americans deserve good health coverage choices. Good coverage options help people manage their health to reduce the chances that they will have a major health problem later. Good options also protect Americans' financial security in the wake of an injury or illness.

Evidence indicates that in many states, individual insurance markets are stabilizing, and choice and competition are increasing for comprehensive individual health care coverage. For the 2019 plan year, one or more new insurers entered the exchange market in 608 counties and the average number of health insurance providers per state was four.[1] More competition and choice means better affordability and value as consumers are able to select a plan that is right for them. We support CMS' intention to prioritize waivers that promote choice and competition rather than one-size-fits-all solutions.

In the interest of promoting choice and competition, we offer a word of caution on the clarification that "access" to comprehensive coverage may meet the statutory guardrail requiring the waiver to provide coverage that is at least as comprehensive as without the waiver. Due to adverse selection, the expansion and promotion of coverage products that are not comprehensive or that charge more or deny coverage for pre-existing conditions could lead to a reduction in the number of comprehensive options over time. This would ultimately reduce the number of coverage options that provide real protection from financial devastation due to an injury or illness. CMS should not approve a waiver that would be reasonably expected to reduce access to comprehensive coverage.

II. Preserving Access to Affordable Comprehensive Coverage

Premium tax credits (PTC) provide support to individuals and families to help them afford coverage and care. But this assistance was designed more broadly to address system-wide issues, including: promoting a stable individual health insurance market for all state residents, including those that do not receive PTC; and ensuring doctors and other providers are compensated for the care they provide. For this reason, PTC eligibility is tied in statute to coverage that: does not deny or limit coverage of pre-existing conditions; meets a federally defined comprehensiveness test; and participates in a federal or state-run risk adjustment program.

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[1] Insurer Participation on ACA Marketplaces, 2014-2019, Kaiser Family Foundation, Rachel Fehr, Cynthia Cox, November 14, 2018

Pass through funding should not be available to plans that limit or exclude coverage for pre-existing conditions; or do not provide comprehensive coverage; or do not participate in the risk adjustment program. Short-term, limited duration insurance (STLDI), mentioned in the guidance and waiver concepts as a candidate for pass through funding, does not currently meet these conditions in any state. A waiver that seeks to provide pass through funding to STLDI or other alternative products should specify what requirements the state will put in place to ensure the alternative coverage meets these conditions.

Rationale Regarding Pass Through Funding

1. Protections for Pre-Existing Conditions

Over 70 percent of Americans say it is very important that pre-exiting conditions protections in federal law be maintained.[2] Under statute, pre-existing condition protections (including guaranteed issue and the market rating rules) cannot be waived under a 1332 waiver. In the letter to the states released with the guidance CMS stated, "This Administration remains firmly committed to maintaining protections for all Americans with pre-existing conditions."

Alternative coverage options, such as STLDI, may charge people with pre-existing conditions higher premiums or deny them coverage altogether. Alternative coverage options may also exclude coverage for pre-existing conditions or not be available to everyone who applies. To maintain protections for people with pre-existing conditions, pass through funding should not be available to coverage options that charge higher premiums, deny enrollment, or exclude coverage of services for pre-existing conditions. Approaches that subsidize alternative coverage with federal dollars could drive healthy people to leave the comprehensive insurance market and undermine access to coverage that does not limit access or coverage for pre-existing conditions. This would increase premiums for comprehensive coverage, whether or not the purchaser receives PTC.

2. Comprehensiveness Guardrail

People expect that things like doctor's visits and trips to urgent care will be covered whether they are related to a new or on-going health issue. Those expectations have been established through the experiences our nation has had over several decades with large group employer-sponsored coverage – where about 180 million people get their coverage today. When we maximize the number of people covered by health insurance that meets or exceeds this basic standard, individual health and well-being improves, and health care is more affordable for everyone.

[2] Poll: The ACA's Pre-Existing Condition Protections Remain Popular with the Public, Kaiser Family Foundation, September 5, 2018

Federal dollars should only be used to buy coverage that meets clearly defined standards for comprehensiveness. Current federal law provides a clear definition for "qualified health plans (QHPs)" sold in the individual market which are eligible for PTC. Most alternative coverage options lack such a clear federal definition. For example, there are no federal requirements for what is covered by an STLDI plan. Some states have specific coverage requirements for STLDI, but most do not.

If coverage does not cover the services people need, or patient cost-sharing greatly exceeds what's permitted for a QHP, more doctors' bills will go unpaid. This means if federal funds are diverted to alternative products that do have clear requirements for what's covered, it's possible that a smaller portion of the federal dollars spent will flow to the doctors and providers that help Americans stay healthy and take care of us when we are sick.

The law does allow a state to obtain a 1332 waiver to provide coverage that is not QHP coverage by waiving essential health benefits (EHBs), federal cost-sharing requirements and other QHP requirements. A state seeking a waiver to redefine coverage standards should clearly describe the coverage that would be available under a new state definition for coverage established through a 1332 waiver.

Similarly, a state seeking to make pass through funding available to alternative options as part of a 1332 waiver application should be required to provide a detailed description of what must be covered. If the coverage is not well defined, charges more or denies coverage for pre-existing conditions, or does not cover pre-existing conditions, then the alternative coverage should not be eligible for pass-through funding.

3. Participation in Risk Adjustment

Currently, most individual health insurance must participate in a statewide risk adjustment program, either the federal program or a state-run program. Per statute, administration of a risk adjustment program cannot be waived under a 1332 waiver. Risk adjustment is critical to maintain a stable individual insurance market that does not discriminate based on pre-existing conditions. Policies that divert new consumers away from the individual insurance market that participates in risk adjustment have the potential to undermine the stability of the risk adjustment program.

III. Increasing Flexibility for State Legislation

We support additional flexibility for states regarding the requirement to submit enacted state legislation with a waiver application, and we offer a word of caution on how this option should be exercised.

Health insurance markets are complicated, and major changes take years to implement and socialize. While some waiver proposals may propose more limited changes, others will have overarching and long-lasting impacts on the health care system. The new flexibility will be very helpful in cases where a governor has the executive authority to propose a 1332 waiver and there is an immediate problem in the individual health insurance market. To ensure stability for years to come, we advise that states should eventually pass state legislation codifying any approved 1332 waiver program to ensure the program is not disrupted in future years.

In some cases, a state may need to pass new laws during the implementation phase of a waiver. For states where appropriate executive authority exists, we support CMS treating as complete a waiver application submitted under executive authority but requiring legislation in the implementation phase. Examples of state legislation that might be required during the implementation phase include but are not limited to state legislation to: appropriate state funds required for the plan or to update state law to allow changes to how state programs coordinate.

IV. Fostering Stability with Formal Rulemaking

Out of an abundance of caution and to maximize certainty surrounding the reliability of any waivers approved under the new guidance, we recommend that CMS reissue this guidance through formal notice and comment rulemaking under the Administrative Procedures Act (APA).