



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

Administrator Verma  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

RE: CMS-9916-P

We, the co-chairs of the Consortium for Citizens with Disabilities (CCD) Health Task Force appreciate the opportunity to comment on the Notice of Benefit and Payment Parameters for 2021.<sup>1</sup> (the Proposed Rule). The CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

The Proposed Rule sets forth benefit and payment parameters, provisions related to essential health benefits (EHBs), qualified health plans (QHPs), risk adjustment, and the operation of Federally-Facilitated Exchanges (FFE) and State-Based Exchanges (SBEs), as well as many other policies implementing the Patient Protection and Affordable Care Act (ACA). This comment letter will focus on key proposed provisions that specifically impact people with disabilities and chronic conditions, including:

- Changes to the automatic enrollment process;
- Inclusion of wellness programs as quality improvement activities
- Changes to the annual limitation on cost sharing;
- Inclusion of prescription drug rebates and other price concessions in medical loss ratio calculations
- Expansion of special enrollment periods; and
- Promotion of value-based insurance design
- Requirement for states to annually report benefit mandates enacted through state law
- Changes to the appeals process

### **Automatic Re-Enrollment**

We are concerned with CMS' proposal to amend the automatic re-enrollment process. Currently, individuals who do not proactively enroll in a new plan during open enrollment are automatically

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<sup>1</sup> Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021, 85 Fed. Reg. 7088 (Feb. 6, 2020). Available at:

<https://www.federalregister.gov/documents/2020/02/06/2020-02021/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021>

re-enrolled in the same or a similar plan. CMS is concerned that enrollees currently paying a \$0 premium do not have sufficient inducement to shop for new plans during open enrollment. CMS has proposed that these enrollees with a \$0 premium would continue to be re-enrolled, but would lose some or all of their Advance Premium Tax Credits (APTCs).

Enrollees with \$0 premiums after APTCs are among the lowest-income enrollees. We are very concerned that enrollees will not understand or anticipate this change. Instead, they will face a surprise premium bill that they do not understand and cannot pay, and will simply lose coverage.

As CMS notes in the preamble, commenters on NBPP for 2020 unanimously supported maintaining the automatic re-enrollment process. According to Health Affairs, a CMS analysis has found that ending automatic re-enrollment would have resulted in 200,000 fewer people enrolled through the exchanges in 2020, and another 100,000 fewer each subsequent year.<sup>2</sup> We do not believe that the costs of this loss of coverage outweighs the benefits of potentially less spending on APTCs. CMS should not implement this proposal in whole or in part.

CMS proposes to increase outreach assistance to encourage enrollees to shop for new plans to avoid this penalty. We propose that CMS use these funds to increase outreach to all enrollees to encourage them to shop for new plans during open enrollment that may save the enrollees and the federal government money.

### **Wellness Programs as Quality Improvement Activities**

CMS has proposed to allow issuers to include expenditures on wellness programs in the individual market as quality improvement activities in their medical loss ratio (MLR) calculations. In September of 2019, CMS issued a bulletin inviting states to participate in a demonstration to implement health-contingent wellness programs in the individual market. This change to MLR calculation should not be permitted because such wellness programs cannot be considered a quality improvement activity. Recent studies have consistently shown that they have no meaningful impact on health outcomes and do not save money. Moreover, we are concerned about newly including wellness program expenditures in the individual market before it is clear whether people with disabilities will be appropriately protected from discrimination individual market wellness demonstration programs. We are concerned that including these expenditures at this juncture will induce more states and plans to implement health-contingent wellness programs without adequate protection against discrimination. Further, evidence from the employer market has shown that wellness programs are not effective at improving health or controlling costs. Therefore, they should not be considered quality improvement activities.

#### *Wellness Programs Do Not Improve Health*

Wellness programs are popular in the employer-sponsored insurance market; according to the Kaiser Family Foundation around 84% of large firms that provide health coverage have a

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<sup>2</sup> <https://www.healthaffairs.org/doi/10.1377/hblog20200201.566219/full/>

wellness plan.<sup>3</sup> Earlier in the decade – around the time of the writing of the Affordable Care Act – wellness programs were seen as a promising way to both improve health and control costs.<sup>4</sup> While early evidence from a 2010 study suggested that employer-based wellness programs could be an effective investment in employee health, that study was later widely critiqued as flawed, and numerous subsequent studies have consistently shown that workplace wellness programs do not achieve either of their stated ends of improving health and controlling health care costs. Indeed, even the lead author of the 2010 study recently reached very different conclusions. In 2019, a randomized control study conducted by two of the same authors of the 2010 study found no significant difference in clinical measures of health, including BMI, blood pressure, or cholesterol as a result of a workplace wellness program.<sup>5</sup> The program also had no significant impact on employee absenteeism, job performance, or health care utilization.<sup>6</sup> The purpose of a demonstration is to determine if a program is effective. In this case, the evidence is in on wellness programs; HHS should not be expanding these ineffective programs to the individual market.

### *Health-Contingent Wellness Programs Discriminate Against People with Disabilities*

Health-contingent wellness programs have the potential to discriminate by penalizing people for disabilities that make it difficult to meet wellness program health targets or participate in required wellness activities, and undermine the Affordable Care Act's protections against medical underwriting. It remains to be seen whether the parameters that HHS has set for the individual market wellness demonstration will be sufficient to protect against discrimination. Even if reasonable alternatives are available, enrollees in the individual market will have fewer resources to understand and participate in these alternative programs or standards, without the assistance of a human resources department or other employer-based assistance.

Without real access to alternative standards, health-contingent wellness programs undermine the ACA's protection against medical underwriting. On the Health Affairs blog Katie Keith writes, "In approving a demonstration for health-contingent wellness program in the individual market, HHS will essentially be exempting issuers from the ACA's ban on health status discrimination."<sup>7</sup> Further, HHS is not requiring states to submit any data on the provision and uptake of these alternative standards to ensure that alternatives are meaningfully available. Without significant federal oversight, wellness programs in the individual market may in fact become the "subterfuge for discrimination" outlawed in the Public Health Services Act.

## **Cost-Sharing Requirements and Manufacturer Coupons**

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<sup>3</sup> Kaiser Family Foundation. Employer Health Benefits 2019 Annual Survey. 2019. Available at:

<http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019>

<sup>4</sup> Baicker K, Cutler D, Song Z. Workplace Wellness Programs Can Generate Savings. Health Affairs. 2010; No. 2. doi: 10.1377/hlthaff.2009.0626

<sup>5</sup> Song Z, Baicker K. Effect of a Workplace Wellness Program on Employee Health and Economic Outcomes: A Randomized Clinical Trial. JAMA. 2019;321(15):1491–1501. doi:10.1001/jama.2019.3307

<sup>6</sup> Ibid.

<sup>7</sup> Keith K. HHS Proposes New Wellness Demonstration Projects. October 1, 2019. Accessed at:

<https://www.healthaffairs.org/doi/10.1377/hblog20191001.231439/full/>

In past rulemaking, CMS proposed allowing issuers to not include the value of manufacturer coupons or other direct support in the calculation of an individual's deductible or annual limitation on cost-sharing, frequently know as Accumulator Adjustment Programs (AAP), if the coupon is used for a brand-name drug for which a generic is available.

In this rulemaking, CMS is proposing to allow issuers to implement AAPs in any circumstance, including for brand-name drugs with no generic. When issuers implement AAPs, beneficiaries are frequently no longer able to afford the medications they need. AAPs are also confusing; beneficiaries find themselves surprised they still owe toward their deductible or out-of-pocket maximum because they did not realize the value of their coupons didn't count.

We encourage CMS to ban the use of AAPs. CCD supports increased options for individuals to lower their out-of-pocket costs, including expanded access to safe and effective generics when appropriate. However, many people with disabilities require brand-name medications because of drug interactions, different effectiveness of generics, and the inability to obtain a list of all ingredients in a generic medication (including the inability to determine whether a generic medication is gluten free). For these beneficiaries, coupons do not induce them to use the brand over the generic, they simply allow beneficiaries to afford their medication and adhere to their medication schedule. For this reason, CCD opposes policies that reduce or unduly restrict coverage of needed brand name drugs to promote generics. Instead we urge CMS to consider alternative approaches to lower prescription drug costs. If AAPs are not banned, CMS should at the very least require that issuers clearly communicate to beneficiaries that their coupons do not count toward their deductible or out-of-pocket maximum.

### **Prescription Drug Rebates and MLR**

CMS is proposing to require issuers to include prescription drug rebates and other price concessions in MLR calculations, including when rebates are retained by pharmacy benefit managers (PBMs). We support this proposal. The CCD Health Task Force has supported reforming the rebate system to ensure that price concessions are passed on to consumers at the point of sale through lower cost sharing. Absent rebate pass through, rebates should be used to lower premiums. Too often, rebates that are retained by PBMs result in both high cost-sharing and high premiums for enrollees. Requiring the inclusion of rebates in MLR calculations should ensure that negotiated concessions result in lower premiums.

### **Expanding Special Enrollment Periods under the Proposed Rule**

CCD supports CMS expanding the special enrollment periods under the Proposed Rule. We understand CMS's concern that enrollees may use the special enrollment process to change qualified health plan metal tiers depending on their health needs throughout the year. However, the proposed additional special enrollment periods allow enrollees to maintain health care coverage to the maximum extent possible, while minimizing this concern. We believe this provision will help ensure that enrollees have access to affordable, comprehensive health care coverage.

### **Value-Based Insurance Design under the Proposed Rule**

CCD is generally supportive of the development of value-based insurance plans that would empower consumers to receive high-value services at lower cost. In the proposed rule, CMS outlines a “value-based” model QHP that contains consumer cost sharing levels aimed at driving utilization of high-value services and lowering utilization of low-value services, when medically appropriate. We urge CMS to ensure that plans are not being designed in a discriminatory manner. Section 1557 of the ACA prohibits health plan issuers from designing plans in a way that discriminates against individuals with disabilities and prohibits discrimination in making decisions about coverage, reimbursement rates, establishing incentive programs, and designing benefits. Accordingly, CCD encourages CMS to promote plan designs that take into account the needs of people with disabilities and chronic conditions.

### **Annual Reporting of State-Mandated Benefits**

CCD opposes the proposals requiring states to annually report benefit mandates enacted through state law. The ACA does require states to identify and defray costs for mandates enacted through state law after December 31, 2011.<sup>8</sup> However, the Center for Consumer Information and Insurance Oversight (CCIIO) already publishes state mandates and the year of enactment on its website. Given this, the proposal is unduly complicated and administratively burdensome for states. The proposal would effectively transfer authority to determine what constitutes a state mandate from state authorities to HHS.

HHS provides no evidence showing that states are violating this federal requirement. In addition, the proposal will render state authority over mandate determinations meaningless, contrary to the intent of both the ACA and corresponding HHS regulations.

The proposal would also impose such a burdensome requirement that it will deter states from improving their EHB benchmark plans. Several states are using current authority to update their EHB benchmark plans and expand services in critical areas. Under HHS’ proposal, states would need to submit an annual report that: identifies all state-required benefits regardless of whether those benefits are considered part of EHB; provides information explaining why the state believes the mandate is or is not part of EHB; and provides information about any mandate that has been amended or repealed. States will likely be reluctant to improve or expand benefits under the EHB benchmarking process, fearing that such improvements may run afoul of the complex mandate reporting requirements.

These requirements represent a significant departure from the current standard, which requires states to inform HHS of state mandates and their corresponding date of enactment, without additional explanation for why the state believes the mandate triggers or does not trigger defrayal. Adopting these new requirements will effectively transform a workable and simple task into an arduous and complicated endeavor put in place as a solution to an inexistent problem. Given this, CCD urges HHS to withdraw this proposal.

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<sup>8</sup> See <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb#ehb>

## Appeals

We are concerned about limiting the choice of consumers to opt for either full retroactive coverage or only prospective coverage if successful with their appeal. Consumers should have the option to request either full or partial retroactive coverage.

HHS notes that issuers have indicated it is difficult to determine how to apply a binder payment given the potential of different circumstances involved (specifically mentioning appeal, non-verified Special Enrollment Period (SEP), or SEP with a delay in verification processing). However if the sole issue is the difficulty of determining an appropriate binder payment, we recommend that HHS develop new processes to more clearly identify the type of binder payment rather than eliminate the option of partial retroactive coverage for consumers.

Some consumers may have valid reasons for requesting partial retroactive coverage. A consumer may have been in an accident or been diagnosed with a new condition or illness during pendency of an appeal that required timely treatment. When successful in the appeal, the consumer may want to obtain retroactive coverage only back to the date of incident or diagnosis rather than the date of application. Depending on how long the appeal took to resolve, it may be a financial hardship for a consumer to have to pay for a long period of retroactive coverage while at the same time could be financially burdened if partial retroactive coverage is not available.

Additionally, in response to HHS' request for comments, we provide the following feedback:

- Appellants who request and are granted eligibility pending appeal should be permitted to enroll in any plan and not be limited in any way to a particular issuer or metal level;
- HHS should not adopt a timeliness standard for requesting eligibility pending an appeal;
- Consumers who experience life events during pendency of an appeal should have their appeals considered resolved in their favor, especially with regards to requests for continuation of benefits pending an appeal and requests for retroactive coverage;
- HHS should apply the three-month grace period to any appeal for which the grace period would normally apply and prohibit issuers from terminating coverage pending an appeal.

We thank you for consideration of our comments. If you have any questions, please feel free to contact Dania Douglas at [ddouglas@lutherservices.org](mailto:ddouglas@lutherservices.org) or (202) 499-5831.

Respectfully Submitted,

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