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March 2, 2020

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

Re: CMS-9916-P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans

Dear Administrator Verma:

The American Kidney Fund (AKF) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule regarding the "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021."

The American Kidney Fund (AKF) fights kidney disease on all fronts as the nation's leading kidney nonprofit. AKF works on behalf of the 37 million Americans living with kidney disease, and the millions more at risk, with an unmatched scope of programs that support people wherever they are in their fight against kidney disease—from prevention through transplant. Through programs of prevention, early detection, financial support, disease management, clinical research, innovation and advocacy, no kidney organization impacts more lives than AKF. AKF is one of the nation's top-rated nonprofits, investing 97 cents of every donated dollar in programs, and holds the highest 4-Star rating from Charity Navigator and the Platinum Seal of Transparency from GuideStar.

Automatic Re-Enrollment Process

CMS proposes to modify the automatic re-enrollment process such that any enrollee who would be automatically re-enrolled with advance premium tax credit (APTC) that would cover the enrollee's entire premium would instead be automatically re-enrolled without APTC. AKF strongly opposes this proposal. We believe it would lead to consumer confusion and jeopardize the coverage of the poorest Americans who could unexpectedly find themselves owing hundreds of dollars in monthly premiums that they cannot afford.

As CMS acknowledges in the proposed rule, automatic re-enrollment significantly reduces issuer administrative expenses, makes enrolling in health insurance more

convenient for the consumer, and is consistent with general health insurance practice. In addition, automatic re-enrollment helps with risk pool stabilization because it retains lower-risk individuals who are less likely to actively re-enroll. However, CMS provides no evidence to justify a modification to the automatic re-enrollment process that specifically targets low-income individuals and families and puts at risk their ability to afford their existing coverage. CMS cites a concern that automatic re-enrollment may lead to incorrect expenditures of APTC, some of which cannot be recovered through the reconciliation process due to statutory caps. But the proposed rule lacks any data to back up that concern or a reasonable justification for a harmful proposal that would treat one group of consumers differently from others who receive APTC. By requiring the poorest consumers to return to the Exchange and obtain an updated eligibility determination or face a much higher (and essentially unaffordable) premium to retain their existing plan, the proposal effectively eliminates automatic re-enrollment for this vulnerable population while maintaining it for others.

CMS notes that if they were to proceed with this change, they would conduct consumer outreach and education alerting consumers to the new process and emphasizing the importance of returning to the Exchange during open enrollment and updating their application. However, it seems unlikely that this outreach effort would sufficiently address the consumer confusion that is likely to occur for people who rely on the automatic re-enrollment process to maintain their zero-dollar plan and who then receive a premium bill costing hundreds of dollars.

If CMS wants to encourage *all* consumers to be more active in their re-enrollment, they could attempt a broader marketing effort that describes the potential benefits of perusing other available plans during open enrollment to make sure individuals are still in the best plan for their needs. The unequal approach to automatic re-enrollment targeting the lowest-income consumers, as proposed in this rule, is unnecessary and would have an adverse impact on this population. We urge CMS to withdraw the proposal and maintain the current auto re-enrollment process for all enrollees.

Special Enrollment Periods

CMS proposes several changes to special enrollment period (SEP) rules, including allowing silver plan enrollees who receive a SEP because they lose eligibility for cost-sharing reductions (CSRs) to switch to a bronze or gold qualified health plan (QHP). Other proposed SEP changes include shortening the time frame between plan selection and the effective date of coverage; offering consumers greater flexibility with plan selection related to enrollment of non-dependents with existing dependent enrollees; changes related to SEP prospective and retrospective effective dates; and clarification related to SEPs for individuals who are provided with a qualified small employer health reimbursement arrangement (QSEHRA).

AKF supports all these proposed changes and clarifications to SEP rules. We believe they will provide consumers with greater flexibility in selecting a QHP that fits their needs and changed life circumstances and removes barriers to enrolling in Exchange coverage.

Premium Adjustment Percentage

CMS proposes to maintain the same premium adjustment percentage index methodology that it revised and adopted for the 2020 plan year. We urge CMS to revisit this methodology and make revisions in this important area that has a significant impact on consumer out-of-pocket costs. The methodology will continue to result in greater rates of increase in out-of-pocket costs for individuals and families than would have occurred in the previous methodology. The proposed 2021 annual limit on cost-sharing is \$8,550 for self-only coverage and \$17,100 for other than self-only coverage, a 4.9 percent increase over 2020 limits.

These increased costs have a disproportionate effect on individuals and families who have serious and chronic conditions that require more health care services. They may forgo or delay care, which can lead to harmful complications and more costs. We ask that CMS revise the premium adjustment percentage index methodology so that it does not unnecessarily accelerate and further shift increased costs on to consumers.

Cost-Sharing Requirements and Manufacturer Coupons

CMS proposes to revise its 2020 policy on direct manufacturer cost-sharing support to provide that amounts paid toward reducing the cost-sharing incurred by an enrollee using any form of direct manufacturer support for specific prescription drugs are permitted, but not required, to be counted toward the annual limitation on cost sharing. This revision is in response to feedback CMS received that raised concerns that the 2020 policy, which applied only to brand drugs that have a generic equivalent, may conflict with an existing Internal Revenue Service (IRS) rule on high deductible health plans with health savings accounts.

AKF urges CMS to withdraw this proposed policy. While we raised concerns with the 2020 policy in our comment letter last year, we appreciate that it was more nuanced, as it had a clear exception for brand drugs without a generic equivalent. The proposed revision for 2021 is more concerning and could affect more patients since it would allow insurers to apply copay accumulator adjustment programs regardless of the availability of a generic equivalent.

We support the introduction and availability of generic drugs, and we support the use of generic drugs when medically-appropriate. However, effective drug regimens depend on how the individual patient responds to a specific drug, and for some patients a brand drug may be more medically-appropriate. Direct manufacturer cost-sharing support such as copay coupons can help patients with chronic conditions access and afford needed medications, and it can help patients adhere to their drug regimens and maintain or improve their health. Therefore, we are concerned that CMS' proposal to allow these copay accumulator adjustment programs will lead to much greater out-of-pocket costs for certain patients with serious conditions, make medically-necessary medication less affordable and accessible for them, and jeopardize their health because they find it more difficult to adhere to their drug regimen. The negative effects fall disproportionately on the enrollee, because the issuer would still accept the manufacturer coupon, but the enrollee must pay much more in cost-sharing to reach their annual deductible and out-of-pocket cap.

CMS' proposal is also concerning because there is no *requirement* for the issuer to inform current and prospective enrollees that their copay assistance will not count towards their annual out-of-pocket limits—CMS only *expects* issuers to be transparent with enrollees and prospective enrollees on this matter. Issuers in various states have implemented copay accumulator adjustment programs recently without adequately informing enrollees of the change to their policies. This has caused a lot of confusion for consumers and unexpected costs for people who rely on copay assistance to afford their medications. Also, as proposed, there is no opportunity for enrollees to appeal the issuer's determination to exclude manufacturer assistance from their annual out-of-pocket cap in a manner similar to that extended to enrollees seeking a formulary exception. Given all these concerns, we urge CMS to not finalize this proposal.

Thank you for your consideration of AKF's comments and recommendations.

Sincerely,



LaVarne A. Burton
President and CEO