HANYS®
Always There for Healthcare

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December 29, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Submitted electronically: www.regulations.gov

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:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, appreciates the opportunity to comment on the Department of Health and Human Services' proposed Notice of Benefit and Payment Parameters for 2022.

HANYS urges CMS to reconsider how the proposed changes would affect the individuals who rely on the Affordable Care Act for their healthcare coverage and to reject any proposals that would adversely affect patients and providers. HANYS is committed to ensuring that consumers have access to affordable, high quality and comprehensive coverage through the federal and state marketplaces.

HANYS is concerned that some of CMS' proposals will weaken patient access to care and may result in the loss of coverage for vulnerable individuals, as well as contribute to the destabilization of the marketplace.

HANYS is concerned that CMS is rethinking changes to coverage and access to care without providing adequate opportunity for stakeholder input. The agency has allowed only 26 days from publication in the *Federal Register* to provide comments, a period that includes a major federal holiday and during a time when hospitals and states are stretched thin due to the COVID-19 public health emergency. HANYS strongly urges CMS to extend the comment period to allow stakeholders across the healthcare system adequate opportunity to assess the impact of the provisions in the rule.

State-based exchanges

HANYS opposes any proposed changes to state-based exchanges that substantially limit a state's authority to control and operate its own health insurance market. The New York State of Health marketplace has had incredible success; more than 4.9 million New Yorkers signed up for healthcare through NYSOH this year. CMS must protect the autonomy exercised by NYSOH and other SBEs and not seek to control the implementation of policy, operations or technical improvements.

Direct enrollment

HANYS strongly objects to CMS' proposal to allow states to opt into an Exchange Direct Enrollment option, moving away from SBEs and allowing private sector entities to market to and enroll consumers directly. This plan would end the SBEs' ability to provide a one-stop shop where all available insurance options are ACA-compliant qualified health plans that cover the essential health benefits. SBEs also allow consumers to determine if they qualify for Medicaid; this model would eliminate that ability.

Instead, allowing SBE-DE would cause confusion for consumers by creating multiple private entities that are incentivized by commissions to compete for enrollment. These entities would be allowed to market insurance options that are not ACA-compliant qualified health plans, exposing consumers to the risk of enrolling in "alternative" products like short-term limited duration insurance plans or incomplete insurance that does not cover the essential health benefits.

HANYS is also concerned that CMS' proposed safeguards would not appropriately mitigate these conflicts of interest and lack of transparency.

SBE-DE would cause unnecessary complications to the health exchanges by adding more websites and competing marketing, requiring consumers to filter through additional insurance options while eliminating some of the assistance that currently exists on the exchanges, like determining qualification for Medicaid and access to enrollment assistors.

New York has successfully run its own one-stop exchange, NYSOH, and reduced the total of uninsured New Yorkers to about 5% of the total population. This proposal would threaten that success by complicating the enrollment environment. Based on these concerns, HANYS asks that CMS not finalize this aspect of the rule.

Section 1332 waivers

HANYS objects to CMS' proposal to codify the Trump administration's sub-regulatory guidance interpreting Section 1332 of the ACA. Section 1332 allows states, with federal approval, to waive certain ACA requirements if a state demonstrates that its proposal meets certain statutory procedural and substantive "guardrails" to ensure state and federal patient protections.

HANYS believes that this October 2018 guidance is substantially laxer than what was originally intended in the ACA and, if codified, would allow states to significantly weaken the goals of the ACA. HANYS is concerned that states will be able to use federal funds to subsidize non-ACA compliant plans, including short-term limited duration insurance plans, resulting in substandard, inadequate coverage for patients. By codifying the guidance, more individuals could be left without insurance coverage or with substandard coverage and uncompensated care would increase. Therefore, HANYS asks that CMS not finalize this proposal.

Special enrollment period allowance
HANYS supports the proposal to allow individuals, enrollees or dependents to select a new plan within 60 days of a special enrollment period triggering event or the date of when they became aware or should reasonably have become aware of a triggering event. Allowing consumers more flexibility to enroll after a triggering event will protect consumers and continue to reduce the uninsured population.

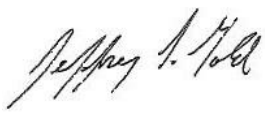
Maximum annual limit on cost sharing
HANYS urges CMS to reverse the change in the formula used to calculate premium tax credits and the premium adjustment percentage adopted in 2019. The continued use of the formula change is harmful and increases the annual limits on cost sharing in 2022 to $9,100 for individual coverage and $18,200 for family coverage, a 6.4% increase from 2021.

Consumers are facing growing amounts of medical debt because of increased financial responsibility, particularly with the upsurge of high-deductible health plans. This has created a new category of under-insured patients who are unable to afford their care, which not only harms patients but also the hospitals and health systems that serve them. Given the COVID-19 public health emergency, access to healthcare is important than ever. CMS should not make accessing such care even harder for patients.

Special enrollment period verification
HANYS opposes the blanket requirement that exchanges must conduct an eligibility review for at least 75% of new enrollees during their special enrollment periods. HANYS supports the NYSOH exchange in determining the appropriate level of reviews for SEP enrollment. The NYSOH exchange already independently verifies loss of minimum essential coverage for persons previously covered by Medicaid, the Basic Health Program, and the Children's Health Insurance Program. There is little data available to verify SEP eligibility, so it would be difficult for exchanges to adhere to a blanket percentage. We also note that insurance plans retain the ability to request eligibility documentation, so this rule appears to be unnecessary. HANYS requests that CMS allow states the flexibility to establish systems in collaboration with the state's insurers that will ensure the integrity of the SEP application process and meet the needs of their consumers.

HANYS appreciates the opportunity to provide feedback on the proposed rule. If you have questions regarding our comments, please contact me at (518) 431-7730 or at jgold@hanys.org or Victoria Aufiero, senior director, insurance, managed care and behavioral health, at (518) 431-7889 or at vaufiero@hanys.org.

Sincerely,



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