July 1, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9936-NC2
P.O. 8013
Baltimore, MD 21244-1850

Re: Request for Information Regarding State Relief and Empowerment Waivers - CMS-9936-NC2

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments in response to the administration's Request for Information (RFI) regarding State Relief and Empowerment Waivers.

By way of background, HBX is a private-public partnership established by the District of Columbia (District) to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). We cover approximately 100,000 people -- District residents and people who work for District small businesses. DC Health Link fosters competition and transparency in the private health insurance market, enabling individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. District residents have 25 health plan options from two insurers and small businesses have 152 health plan options from United, Aetna, CareFirst, and Kaiser. Since we opened for business, we've cut the uninsured rate by 50% and now more than 96% of District residents have health coverage.

HBX supports efforts to expand affordable quality health coverage, state flexibility under the ACA, and state innovation using section 1332. However, the approach articulated in the RFI is not about state flexibility. It is about turning back the clock to pre-ACA days of underwriting and discrimination. The RFI explicitly reiterates the principles CMS articulated in its 2018 guidance[1] encouraging the growth of junk plans and putting at risk quality health insurance that millions of Americans rely on. We expressed our concerns in 2018 over such policies and continue to have the same concerns now.

The contemplated approach to Section 1332 waivers and 2018 guidance fails to protect people with preexisting conditions, allows states to revert back to the pre-Affordable Care Act (ACA) environment where many consumers, including those with pre-existing conditions, would not have affordable comprehensive coverage and would be forced to seek inadequate coverage in markets that permit medical underwriting, and allows charging sicker people higher rates or denying coverage altogether.

[1] Depts. of Health and Human Services and Treasury, Guidance: State Relief and Empowerment Waivers, 83 Fed. Reg. 53575, Oct. 23, 2018.

Consequently, premiums will increase for District residents with private individual market health insurance. To avoid these negative consequences, we recommend that the Administration reestablish a federal reinsurance program to strengthen the existing individual markets. Seven of the eight approved Section 1332 waivers establish a state-level reinsurance program and six of the seven states with public drafts of a Section 1332 waiver application are to establish a state-level reinsurance program.[2]

Adverse Impact on States that Keep ACA Protections

The CMS approach articulated in 2018 and reiterated in the RFI will have a negative impact on individual private health insurance markets in states like the District of Columbia that keep ACA consumer protections. As articulated in our Comment letter[3], if other states seek section 1332 waivers to permit the proliferation of junk plans that are not required to include the ACA's consumer protections, individuals who have higher health costs and who need more comprehensive coverage will move to states like the District that retain the ACA's consumer protections. According to Oliver Wyman actuaries, if other states make significant changes to consumer protections of the ACA (e.g., coverage no longer being available to individuals on a guaranteed issue basis, the elimination of community rating, increased availability of plans in separate risk pools from the ACA), the impact of higher cost individuals moving into the District will have a significant negative affect on District residents with individual coverage.

- If merely 100 people who are high cost move to the District from states that weaken ACA protections, claims costs for the individual market will increase by 8.9% and if approximately 800 high cost people move to DC, claims costs will **increase by 24.4%**. (Attachment: Oliver Wyman Analysis)

This concern was true in 2018 and continues to be the case now. CMS's approach to Section 1332 waivers will harm people who live in the District and will harm other states that keep ACA consumer protections.

Harm to Consumers in States that Erode ACA Consumer Protections

CMS's approach to Section 1332 waivers will harm people who live in states that allow the erosion of ACA protections for people with preexisting conditions.

CMS clarified in 2018 and reinforced in the RFI that in evaluating the affordability and comprehensiveness guardrails, they will look at the impacts in the aggregate and not focus on the impacts on vulnerable populations. This would allow states to create waiver programs that disadvantage specific populations, such as lower income or people with chronic illnesses, so long as the

[2] H. Howard, State Health and Value Strategies, More States Looking to Section 1332 Waivers, June 3, 2019, https://www.shvs.org/more-states-looking-to-section-1332-waivers/. States with a reinsurance program under 1332: Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon and Wisconsin. States working on their 1332 applications for a reinsurance program: Colorado, Delaware, Louisiana, New Hampshire, North Dakota, and Rhode Island.

[3] Comment Letter from Mila Kofman, Executive Director, DC Health Benefit Exchange Authority to Secretary Azar and Administrator Verma, Dept. of Health and Human Services on State Relief and Empowerment Waivers – CMS-9936-NC, Dec. 17, 2018 available at https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/DC_HBX_Comment_CMS_9936-NC.pdf.

aggregate population might experience some benefit (for example, lower premiums for junk insurance). Specifically, the Section 1332 State Relief and Empowerment Waiver Concepts: Discussion Paper released on November 29, 2018 encourages use of the 1332 waiver to promote short-term limited duration plans (STLD), association health plans (AHPs), and other junk insurance not subject to the same consumer protections as health insurance for individuals and small businesses.

Proliferation of junk plans results in risk segmentation and makes comprehensive coverage less affordable and less available. For example, STLD plans are designed only to cover healthy people by using medical underwriting to reject people with medical needs. Such plans also don't cover preexisting conditions, exclude prescription drugs, maternity care and mental health benefits, and have annual and lifetime limits. When healthy people leave the ACA market and purchase junk plans, premiums increase for people with comprehensive coverage and ultimately makes comprehensive coverage unaffordable. Also, this could result in insurers leaving the ACA market in states that segment markets through the use of section 1332 waivers.

We are concerned that the Administration's approach will cause consumers who need comprehensive coverage and people with preexisting conditions to lose their ACA coverage. We are also concerned that people who want comprehensive private health insurance will no longer have insurance companies from which to buy coverage.

Violation of Section 1332 State Innovation Waiver Guardrails

CMS's waiver guidance misinterprets and contradicts the statutory guardrails for 1332 waivers. Section 1332(b) of the ACA establishes clear statutory guardrails (emphasis added):

> **(1) IN GENERAL -** The Secretary may grant a request for a waiver under subsection (a)(1) only if the Secretary determines that the State plan—
>
> **(A)** will provide coverage that is at least as comprehensive as the coverage defined in section 18022(b) of this title and offered through Exchanges established under this title as certified by Office [3] of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;
>
> **(B)** will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide;
>
> **(C)** will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; **and**
>
> **(D)** will not increase the Federal deficit.

The statute requires a state waiver program to provide comprehensive, affordable coverage with cost sharing protections against excessive out-of-pocket spending to a comparable number of residents as would have been covered but for the waiver. The CMS approach articulated in 2018 and reinforced in the RFI conflicts with the statute for the following reasons.

CMS asserted in the 2018 guidance and in the RFI reinforces the idea that a state can meet these guardrails by showing that residents will have *access* to affordable and comprehensive coverage. The guidance does not require any enrollment in affordable and comprehensive coverage. The interpretation contradicts plain meaning of the statute which requires that state waiver programs

actually **cover** a comparable number of people under comprehensive coverage. The author of Section 1332, Senator Ron Wyden, on the Senate floor on December 23, 2009 made this clear by stating (emphasis added):

> Exchanges are a new pathway to creating a competitive marketplace for the first time for health care in this country. Massachusetts led the way, opening the door to showing Federal legislators the potential for insurance exchanges when Massachusetts enacted its own health reform law. Many other states lead the way with innovation in health care, including states like Oregon and Vermont. That is why I have authored and championed in the Senate Finance Committee, section 1332, the waiver for State innovation. If States think they can do health reform better than under this bill, and **they cover the same number of people with the same comprehensive coverage**, they can get a waiver exempting them from the legislation and still get the Federal money that would have been provided under the bill.

By interpreting "provide coverage" as merely access to coverage as opposed to actual enrollment, CMS's interpretation conflicts with the statute.

Furthermore, CMS's current approach conflicts with the guardrails. CMS encourages the growth of junk plans such as STLD plans and AHPs that do not have the same cost protections against excessive out-of-pocket spending and are not available to people with preexisting conditions or can keep people out through medical underwriting. Allowing this means people with medical needs would not drop their comprehensive coverage but healthy people would. As enrollment in junk plans increases, enrollment in ACA plans will decrease driving up premiums for comprehensive coverage, affecting people who do not qualify for tax credits. Consequently, facilitating the growth of junk plans conflicts with the statutory guardrails.

- STLD and AHPs do not provide comprehensive coverage or are underwritten and therefore do not meet the standards in section 1332(b)(1)(A) and therefore residents enrolled in these plans cannot be counted as toward the requirement that the waiver program cover a comparable number of residents.
- As premiums rise due to increased enrollment in STLD and AHPs, the result will be that comprehensive coverage is less affordable for unsubsidized people, a violation of section 1332(b)(1)(B), which requires affordability to be maintained.
- As healthy people drop comprehensive coverage, it will result in fewer people being covered by comprehensive, affordable coverage with cost sharing protections, a violation of section 1332(b)(1)(C), which requires coverage levels to be maintained.
- Comprehensive, affordable coverage would not even be *available* to a comparable number of people because premiums would be higher.

Furthermore, CMS will allow states to use federal funds to pay for STLD plans, AHPs, and other plans not subject to ACA consumer protections, such as the prohibition on pre-existing condition exclusion periods, guaranteed availability, community rating, and the requirement to provide essential health benefits. There is no provision in the ACA that allows federal tax dollars to be used to subsidize substandard coverage. CMS's interpretation violates the 1332 guardrails that require waiver programs to ensure that a comparable number of residents are covered under affordable and comprehensive health insurance.

Conclusion

HBX supports efforts to expand affordable quality health coverage, state flexibility under the ACA, and innovation using section 1332. However, we strongly oppose CMS's current approach because it undermines stability of quality affordable health insurance, puts millions of Americans at risk of losing their health insurance, and will increase premiums for people living in states like the District of Columbia that keep ACA protections. CMS's approach fails to protect people with pre-existing conditions and is contrary to the statutory language of the 1332 waiver standards. We request withdrawal of the current approach and the 2018 guidance. Instead, we recommend that CMS establish a federal reinsurance program.

Thank you for considering our comments.

Sincerely,

Mila Kofman
Executive Director
DC Health Benefit Exchange Authority