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December 23, 2018

VIA ELECTRONIC SUBMISSION

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

Re: State Relief and Empowerment Waivers Guidance
File Code: CMS-9936-NC

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and under-served people. We appreciate the opportunity to provide these comments on the State Relief and Empowerment Waivers guidance ("2018 Guidance").

We recommend that the Departments of Health and Human Services and Treasury ("Departments") retract the 2018 Guidance because it is in direct conflict with numerous statutory requirements and will likely lead to harm for millions of individuals.

The 2018 Guidance Violates Numerous Statutory Provisions

The Departments' new guidance conflicts with several core provisions of section 1332 of the Affordable Care Act ("ACA"), including all four of the statutory "guardrails" (found at § 1332(b)(1)), provisions themselves explicitly designed to ensure compliance with the ultimate objectives of the ACA.

Numerous features of the guidance violate the statutory requirements in section 1332, including:

- The 2018 Guidance allows the guardrails of comprehensiveness and affordability to be met by giving

individuals “access to coverage” even if they do not “actually purchase” that coverage.¹ The statute requires a comparison based on the coverage the waiver “will provide” to the 1332 population.² The 2018 Guidance appears to sever the comprehensiveness and affordability guardrails from the comparable number guardrail, while the statute applies all of the guardrails to the entire 1332 waiver population in unison.

- The 2018 Guidance impermissibly creates a new, undefined “meaningful” coverage standard for the comparable number guardrail.³ But the statute sets the Essential Health Benefits standard as a minimum for coverage.⁴
- The 2018 Guidance appears to allow states to satisfy the comprehensiveness and affordability guardrails by relying on coverage changes in populations outside the waiver group.⁵ The statutory calculation is a review of the relevant Marketplace coverage before and after the waiver.
- The 2018 Guidance allows states authorize section 1332 waivers using general and “existing legislation if it provides statutory authority to enforce PPACA provisions and/or the state plan.”⁶ The 1332 statute, however, requires states to enact specific legislation to make state actions under 1332 and implement state plans under 1332.⁷
- The 2018 Guidance may allow states to sell non-ACA compliant plans on Marketplaces side-by-side with compliant plans, and effectively allow waivers of provisions that are not waivable under section 1332.⁸ The statute clearly limits the provisions that are waivable under section 1332 and only allows states to sell ACA compliant plans on the Marketplace.⁹

These provisions not only violate the language of section 1332, they also contradict the intent of section 1332 and the entire statute. The overarching intent of the ACA included increasing the number of individuals with health care, ensuring all individuals with insurance have a sufficient set of benefits, and protecting affordability for enrollees. While Section 1332 was designed to create some flexibility for states, it was explicitly written with guardrails to ensure that the statutory intent with respect to quantity, quality, and cost of coverage was preserved. The 2018 Guidance violates the letter of section 1332 as well as the intent of 1332 and the ACA.

¹ Department of the Treasury and Department of Health and Human Services; State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575, 53577 (Oct. 24, 2018).

² Affordable Care Act (ACA) § 1332(b)(1)(A) and (B).

³ 83 Fed. Reg. 53,579.

⁴ ACA § 1332(b)(1)(A).

⁵ 83 Fed. Reg. 53,578-79.

⁶ 83 Fed. Reg. 53,582.

⁷ ACA § 1332(a)(1)(C).

⁸ 83 Fed. Reg. 53,581.

⁹ ACA §§ 1332(a) and 1311(d).

The 2018 Guidance also changes the waiver impact analysis to “focus on the aggregate effects of a waiver,” thus allowing improvements for some groups to be offset by losses to other groups, including vulnerable populations.¹⁰ This reverses the sensible current policy and will likely lead to numerous violations of civil rights and nondiscrimination laws, including the Americans with Disabilities Act, the Rehabilitation Act of 1973, the Civil Rights Act of 1964, and section 1557 of the ACA.

The 2018 Guidance Will Be Harmful to Individuals

The violations of the statute noted above are not just unlawful, they are also bad as a matter of health policy. They will result in harm to millions of enrollees and damage the health insurance market.

Essential Health Benefits

The ACA requires coverage of Essential Health Benefits (“EHB”). This provision was included to address abysmal gaps in covered services in the individual market insurances prior to the ACA’s implementation. The EHB requirement has helped ensure people have access to *basic* health care services and has closed health care coverage gaps that for decades had left individuals underinsured. Before the ACA, consumers often did not have health coverage for services that are now covered as EHBs. For example, prior to the ACA, one in five people enrolled in the individual market lacked coverage of prescription drugs and mental health coverage was often excluded from health plans.¹¹ Also, 75% of non-group market plans did not cover maternity care (delivery/inpatient care), and 45% did not cover inpatient/outpatient substance use disorder services.¹² These services can be a small percentage of the relative benefit costs in commercial market plans, yet scaling back on their coverage would significantly raise out-of-pocket costs for individuals who need them.¹³

The Departments’ guidance threatens women’s access to comprehensive health care and harms the economic security and well-being of women and their families. Because of the ACA, women now have robust coverage that provides access to essential services, including reproductive health services. Prior to the ACA, women often paid for inadequate coverage that did not meet the full range of their health needs. For example,

¹⁰ 83 Fed. Reg. 53,578.

¹¹ Dania Palanker et al., *Eliminating Health Benefits Will Shift Financial Risk Back to Consumers*, The Commonwealth Fund, Mar. 24, 2017, <http://www.commonwealthfund.org/publications/blog/2017/mar/eliminating-essential-health-benefits-financial-risk-consumers>.

¹² Gary Claxton et al., *Would States Eliminate Key Benefits if AHCA Waivers are Enacted?*, Kaiser Family Foundation, June 14, 2017, <https://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/>.

¹³ Rebekah Bayram & Barbara Dewey, *Are Essential Health Benefits Here to Stay?*, Milliman, March 2017, <http://us.milliman.com/uploadedFiles/insight/2017/essential-health-benefits.pdf>.



many plans that covered maternity services were not affordable. One study discovered that many individual plans charged a separate deductible for maternity coverage that was as high as \$10,000 and some plans forced individuals to wait up to a year before their maternity care would be covered.¹⁴ Coverage of maternity care and newborn care is also critically important for women of color and their children. In 2015, infant mortality rates were particularly concerning for communities of color.¹⁵ The Departments' proposed policy could leave many women and their families without the care they need when they need it.

Under the Departments' guidance, people who rely on services that are no longer required as EHBs will have to pay out-of-pocket for them or forgo the care they need. If the EHB definition is changed, the out-of-pocket maximum and annual and lifetime limit consumer protections may no longer apply to services that are not considered EHBs since these protections only apply to EHBs. This will increase health care costs for many, including people with pre-existing conditions.¹⁶ It will also drive up medical debt and health-related bankruptcies, which have ameliorated since the ACA was enacted.¹⁷

The mere creation of at least one option for EHB coverage is not sufficient. First and foremost, the statutory language and intent is on requiring the EHB as a minimum for all plans, not in creating in EHB *option*. Second, many consumers are unable to assess the level of care they need, and of course no consumer can predict the unexpected health problems that may arise over the full coverage year, thus all plans should meet the EHB minimum. Third, as discussed more below, allowing substandard cheap plans will segment the risk pool, harming higher needs consumers and the health insurance market broadly. For all of these reasons, the Departments' allowance of non-EHB plans is bad policy in addition to being unlawful.

¹⁴ NAT'L WOMEN'S LAW CTR., TURNING TO FAIRNESS: INSURANCE DISCRIMINATION AGAINST WOMEN TODAY AND THE AFFORDABLE CARE ACT, 11 (Mar. 2012), https://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf.

¹⁵ In 2015, the infant mortality rate per 1,000 live births was 5 percent for Hispanic infants, 8.3 percent for American Indian/Native Alaskan infants, 11.3 percent for Non-Hispanic Black infants, compared to 4.9 percent for non-Hispanic White infants. *Infant Mortality*, Centers for Disease Control and Prevention, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm> (last updated Aug. 29, 2017).

¹⁶ Sarah Lueck, *Administration's Proposed Changes to Essential Health Benefits Seriously Threaten Comprehensive Coverage*, Center on Budget and Policy Priorities, November 7, 2017, <https://www.cbpp.org/research/health/administrations-proposed-changes-to-essential-health-benefits-seriously-threaten>.

¹⁷ Allen St. John, *How the Affordable Care Act Drove Down Personal Bankruptcy*, Consumer Reports, May 2, 2017, <https://www.consumerreports.org/personal-bankruptcy/how-the-aca-drove-down-personal-bankruptcy/>.

These plans, despite their complete inadequacy and grave social consequences, operated as minimum essential coverage that would ostensibly satisfy the Departments "meaningful" coverage standard -- itself a somewhat meaningless standard. Permitting anything less than the EHB benefits package would be a harmful regression for individuals.

Affordability

The ACA includes a specific combination of protections to make coverage affordable for enrollees. This too is a minimum that was set in place as a required floor -- not an *option* -- to ensure that individuals could afford coverage. (In fact, if anything, our experience is that lower-income individuals need more subsidization to support their Marketplace enrollment).

Prior to the ACA, many individuals were uninsured because they could not afford coverage premiums. Many others had coverage but could not afford to use it, because per service co-pays or cost-sharing were unaffordable, or deductibles were astronomical, or the cumulative out-of-pocket cost became unsustainable. The ACA's affordability protections have begun to solve this problem.

As with benefits, the mere creation of at least one affordable coverage option is not sufficient. First, again, the statutory language and intent is on requiring affordability protections as a minimum for all plans, not in creating an affordable *option*.

Second, even sophisticated consumers may struggle to estimate the cost of their expected care, factoring in premiums, co-pays, cost-sharing, deductibles, out-of-pocket minimums, out-of-network charges, services that do and do not count towards the deductible, benefits tiering costs, etc. And of course no consumers can accurately guess the cost of their unexpected care. Many, many consumers facing this impossible calculation simply rely on the easiest price points -- premium cost and deductible -- a notoriously limited way to understand a plan's true cost.¹⁸ Consumers will often be unable to calculate which plan is the statutorily-mandated affordable option. In short, consumers will often choose a plan that "looks cheap" because they lack information. In many cases they end up with a plan that does not meet their needs, and end up spending far more in (for example) cost-sharing than they would have out of pocket in a slightly higher premium plan (or, they may simply forgo needed care). The ACA has helped to solve this problem, and the Departments should not re-create the problem.

Comparable Number

One of the principle goals of the ACA was to increase the number of individuals with quality health insurance.¹⁹ We believe that access to health care is a human right that should be advanced as a moral end in and of itself.

¹⁸ Choose to Lose: Health Plan Choices from a Menu with Dominated Options Quarterly Journal of Economics, Vol. 132, Issue 3, pp. 1319-1372, 2017

¹⁹ See Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. at 2606.

Congress had numerous additional reasons to increase the number of individuals with health coverage. Health coverage is correlated to improved health outcomes.²⁰ Prior to the ACA, medical debt was the leading cause of family bankruptcies.²¹ Health coverage leads to a stronger, more productive workforce. Reducing uninsurance also reduces uncompensated care and bolsters the financial stability of the health system, particularly in rural areas.²²

For these reasons, and many more, an overriding goal of the ACA was to increase coverage rates, and section 1332 was explicitly written to preserve this objective. (And this coverage was written to always include the EHB package and ACA affordability protections.) The Departments would do great harm to enrollees by allowing 1332 waivers that do not cover a comparable number of individuals in quality coverage.

Risk Pools & Market Stability

The ACA was not only intended to help uninsured individuals, it was also designed to strengthen health insurance markets. One important way this is being accomplished is by broadening risk pools. Prior to the ACA, low-value individual market product attracted a small pool of healthy individuals, leaving no options or prohibitively expensive options for other individuals.²³ This segmentation in the market led to numerous problems, including uninsurance, insurance “death spirals,” cost-shifting, and defensive price increases to address uncertainty. All of these things drove up costs for everyone while sowing instability in the entire insurance market.

The ACA -- through minimum benefits and affordability standard, guaranteed issue and renewability requirements, rating standards, etc. -- assures all individuals the chance of purchasing insurance and has led to larger and broader risk pools. This in turn has led to less problems with uninsurance, cost-shifting, and death spirals. (Defensive price increases are still a problem; but this not because of ACA coverage policies, it is

²⁰ Benjamin D. Sommers, Atul A. Gawande, and Katherine Baicker, *Health Insurance Coverage and Health — What the Recent Evidence Tells Us*, 377 N. Engl. J. Med. 586 (August 10, 2017).

²¹ Michael Hiltzik, *Another Little-Mentioned Benefit of Obamacare: It Has Reduced Medical Bankruptcies*, L.A. Times, May 9, 2017, <https://www.latimes.com/business/hiltzik/la-fi-hiltzik-obamacare-bankruptcy-20170509-story.html>.

²² Matt Broaddus, *Affordable Care Act's Medicaid Expansion Benefits Hospitals, Particularly in Rural America*, Center on Budget and Policy Priorities, June 23, 2017, <https://www.cbpp.org/research/health/affordable-care-acts-medicaid-expansion-benefits-hospitals-particularly-in-rural>.

²³ Sara R. Collins, Munira Z. Gunja, Michelle M. Doty, and Sophie Beutel, *How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own*, Commonwealth Fund, February 2017, https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2017_feb_1931_collins_biennial_survey_2016_ib.pdf.



because of the numerous threat to *repeal* ACA coverage provisions.) The Departments should not pursue a policy that leads us back to that inefficiency.

Conclusion

Thank you for your attention to our comments. If you have any questions or need any further information, please contact Leonardo Cuello at cuello@healthlaw.org.

Sincerely,

Leonardo Cuello
Director, Health Policy

