February 19, 2019

The Honorable Seema Verma
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted electronically via https://www.regulations.gov

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020 [RIN: 0938-AT37 | Docket Number: CMS-9926-P]

Dear Administrator Verma:

The American Nurses Association (ANA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed rule entitled, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020" (the NBPP).

ANA is the premier organization representing the interests of the nation's 4.0 million registered nurses (RNs), through its state and constituent member associations, organizational affiliates, and individual members. ANA advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of nurses, and advocating on health care issues that affect nurses and the public. RNs serve in multiple direct care, care coordination, and administrative leadership roles, across the full spectrum of health care settings. RNs provide and coordinate patient care, educate patients and the public about various health conditions including essential self-care, and provide advice and emotional support to patients and their family members. ANA members also include the four advanced practice registered nurse roles (APRNs): nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse-midwives (CNMs) and certified registered nurse anesthetists (CRNAs). ANA is dedicated to partnering with health care consumers to improve practices, policies, delivery models, outcomes, and access across the health care continuum.

ANA's principles of health system transformation, official position statements, and *The Code of Ethics for Nurses* outline ANA's commitment to ensuring universal access to quality, affordable, and accessible health care services for all Americans. ANA's comments in response to this proposed rule focus on the provisions that will likely either advance or impede that commitment.

ANA supports CMS' decision to continue to permit silver loading for 2020.

ANA appreciates that CMS' NBPP for 2020 does not disrupt market stability by banning "silver loading." As the Agency noted in preamble to the NBPP:

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> On January 20, 2017, the President issued an Executive Order which stated that, to the maximum extent permitted by law, the Secretary of HHS and heads of all other executive departments and agencies […] should exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the PPACA that would impose a fiscal burden on any state or a cost, fee, tax, penalty, or regulatory burden on individuals, families, health care providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers of medical devices, products, or medications.[1]

Banning silver loading without ensuring that issuers are reimbursed for the cost-sharing reduction (CSR) subsidies would impose a fiscal burden on both individuals and insurers in conflict with the Executive Order, disrupt the health insurance market, and significantly increase premiums for consumers seeking any level of coverage under the PPACA. CMS' decision to continue permitting plans to offset their CSR expense through silver loading through the 2020 plan year, while not a perfect solution, will ensure that patients, particularly those with chronic diseases and disabilities, are empowered to choose the plan that best suits their needs.[2]

ANA urges CMS to approach this issue in future years with the same focus on market stability and patient access that has driven the 2020 NBPP proposal. A future ban on silver loading would result in up to seven million non-subsidized enrollees paying more for no additional benefit. In addition, up to 1.8 million subsidized enrollees would lose access to lower-premium bronze and gold plans that they were able to enroll in during 2018.[3] In August, 2017, the Congressional Budget Office (CBO) estimated that not funding the CSRs would increase the federal deficit by $6 billion in 2018, $21 billion in 2020, and $26 billion in 2026 – a cumulative deficit increase of $194 billion during the period 2017 to 2026.[4] We urge CMS to prioritize direct funding of the CSRs within its set of initiatives to reduce health care costs while improving access to affordable care. Should Congress not act on this issue, ANA urges CMS to avoid banning silver-loading unless the Agency implements a more permanent regulatory mechanism to effectuate continued funding of the CSRs.

ANA urges CMS to withdraw its proposed changes to the calculation of the PPACA's 'Premium Adjustment Factor.'

CMS proposes changes to calculation of the premium adjustment factor used to determine the annual adjustment in the amount subsidized marketplace enrollees contribute to plan premiums, the cap on

[1] Id.

[2] These expectations are consistent with the experience in the five states that chose to broad load their CSRs on all qualified health plan premiums in 2018: these states lost more enrollment, on average, relative to other states that allowed or required silver loading. In states that use HealthCare.gov, those with broad loading had no county with a gold plan that was less expensive than the silver benchmark plan. In contrast, states that used silver loading had more than 500 counties with at least one gold plan that was less expensive than the silver benchmark plan (meaning consumers had lower-price options for more generous gold plans).

[3] Calculated from 2018 Marketplace Open Enrollment Period Public Use Files

[4] Congressional Budget Office, The Effects of Terminating Payments for Cost-Sharing Reductions, https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf

annual out-of-pocket spending, the amount insurers pay via the health insurance tax, and the fine for employers who fail to offer affordable coverage to their employees. ANA is concerned about the potential impact of this provision of the NBPP on individuals with chronic diseases and disabilities, due to a worsening of the PPACA risk pool as well as an expected out-of-pocket cost increase of $400 per year**.** HHS estimates that the proposed change in formula will result in net premium increases of over $180 million per year and a decline of approximately 100,000 marketplace enrollees in 2020.[5] We urge CMS to withdraw this proposal or counterbalance it with enhanced protections for individuals with chronic diseases and disabilities.

ANA supports CMS' efforts to increase access to medication-assisted treatment (MAT) for opioid use disorder (OUD).

ANA appreciates CMS' efforts to ensure that individuals suffering from OUD have access to evidence-based MAT to increase their chance for recovery. In its NBPP, CMS encourages health plans to provide comprehensive coverage of MAT, even if the applicable EHB-benchmark plan does not require the inclusion of all MAT on the plan's formulary.

According to the American Society for Addiction Medicine:

> Relative to treatment without medication, office-based opioid treatment with buprenorphine improves six-month treatment engagement, significantly reduces cravings, illicit opioid use and mortality, and improves psychosocial outcomes. Importantly, agonist therapy has been shown to decrease mortality by approximately 50% among persons with opioid-use disorder.[6]

ANA believes that excluding a treatment option that is associated with a 50% decrease in mortality is an example of a discriminatory benefit design. We agree that plans excluding MAT for opioid use treatment, but covering it for other medically necessary purposes, (e.g., analgesia) should be required to justify the basis for the exclusion and explain how the benefit design is not discriminatory under the PPACA's non-discrimination rules. We urge CMS to consider going further in implementing a broader, more robust mechanism to ensure that issuers are actively working toward, not against, the public policy imperative of curbing the opioid use epidemic. Specifically, we ask that CMS:

- encourage or require states to update their benchmark plan to include all formulations of MAT; and
- inform issuers that a benefit design excluding MAT for opioid use disorder will be presumed to be discriminatory.

[5] Id.

[6] American Society of Addiction Medicine, Public Policy Statement, Regulation of Office-Based Treatment, https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2018/01/18/regulation-of-office-based-opioid-treatment (accessed February 12, 2019).

ANA believes that the important modifications outlined above are crucial in ensuring the proposed 2020 NBPP could reduce costs for exchange enrollees without compromising care. We look forward to the opportunity to further engage with CMS regarding strategies to implement these policies. If you have questions, please contact Ingrida Lusis, Vice-President, Policy and Government Affairs (Ingrid.Lusis@ana.org or (301) 628-5081).

Sincerely,

Debbie Hatmaker, PhD, RN, FAAN
Chief Nursing Officer / EVP

cc: Ernest Grant, PhD, RN, FAAN, ANA President
Loressa Cole, DNP, MBA, RN, NEA-BC, FACHE, ANA Chief Executive Officer

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