December 24, 2018

VIA ELECTRONIC SUBMISSION

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

Re: CMS-9936-NC, State Relief and Empowerment Waivers

Dear Administrator Verma:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the **State Relief and Empowerment Waivers (1332 waivers) guidance.** Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year.

The Patient Protection and Affordable Care Act (ACA) created important opportunities for un- and underinsured people to gain affordable health coverage. This has proven especially vital for people who are approaching Medicare eligibility. Those between ages 55 and 64 made up around 26% of Marketplace enrollees in 2015, nearly 3.3 million people.[1] People with disabilities also have coverage through the ACA, including those who are in the two-year waiting period for Medicare coverage and people who are still working through the formal disability process. The ages and health statuses of many of these individuals means that without the ACA's robust consumer protections—such as community rating and pre-existing condition protections—they might be unable to access affordable, or in some cases any, comprehensive health coverage.

[1] Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report for the Period November 1, 2015 – February 1, 2016" (March 11, 2016) https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf.

States are permitted to make limited changes to some ACA functions within the state through 1332 waivers, though these changes must meet procedural and substantive standards and cannot upend the community rating and pre-existing condition protections. Before being granted a waiver, the state must demonstrate how the waiver will provide for coverage that is "at least as comprehensive" and "at least as affordable" and covering "at least a comparable number of its residents" without increasing the federal deficit.[2]

We are therefore greatly disappointed to see new guidance from the Centers for Medicare & Medicaid Services (CMS) that encourages states to apply for 1332 waivers that provide increased access to association health plans and shorter-term limited duration plans that explicitly need not—and in practice do not—include pre-existing condition or community rating protections. The agency attempts to sidestep the requirement that states guarantee these protections by claiming that it does not matter if consumers actually get the consumer protections so long as they are available from a product the consumer could have purchased. States would also no longer need to show that the coverage meets minimum essential coverage standards and is both comprehensive and affordable.

This guidance is a significant misstep that threatens to undo many of the ACA's advances for older adults and people with disabilities. By allowing states to skirt the health law's 1332 guardrails, CMS would be encouraging the creation of a system with increased pre-existing condition exclusions, increased plan underwriting, increased out-of-pocket expenses for people with these inferior plans and, eventually, increased costs for the Medicare program as people reach Medicare eligibility in poorer health.[3]

But it is not simply bad policy. This guidance encourages states to violate the ACA's statutory requirements. CMS cannot simply abdicate its legal responsibility to ensure that any changes a state seeks through a 1332 waiver will result in coverage that is "at least as comprehensive" and "at least as affordable" and covers "at least a comparable number of its residents." Short-term and association health plans do not meet these standards. They are not at least as comprehensive as ACA-compliant plans and, while they are superficially "affordable" if we look solely to premiums, they do not provide coverage that protects the economic stability of enrollees. Limiting the definition of "affordability" to premiums alone willfully disregards the minimal coverage these plans provide and the high out-of-pocket costs awaiting those who

[2] 42 U.S.C. § 18052 "Waiver for State innovation."

[3] Jack Hadley & Timothy Waidmann, "Health Insurance and Health at Age 65: Implications for Medical Care Spending on New Medicare Beneficiaries," Health Serv Res. 2006 Apr; 41(2): 429–451 (April 2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1702516/ ("Continuous insurance coverage is associated with significantly fewer deaths prior to age 65 and, among those who survive, a significant upward shift in the distribution of health states from fair and poor health with disabilities to good to excellent health. Treating insurance coverage as endogenous increases the magnitude of the estimated effect of having insurance on improved health prior to age 65. The medical spending simulations suggest that if the near-elderly had continuous insurance coverage, average annual medical spending per capita for new Medicare beneficiaries in their first few years of coverage would be slightly lower because of the improvement in health status. In addition, total Medicare and Medicaid spending for new beneficiaries over their first few years of coverage would be about the same or slightly lower, even though more people survive to age 65.")

purchase them should they experience an adverse health condition. In suggesting otherwise, CMS is ignoring the plain text of the statute.

This combination of bad policy and bad legal reasoning is irreparable. Instead of allowing the guidance to stand, CMS should withdraw it immediately.

Thank you again for this opportunity to comment. We look forward to working together to advance policies to increase health coverage and avoid a rise in under- or uninsured individuals For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Joe Baker
President
Medicare Rights Center