

November 27, 2017

The Honorable Eric D. Hargan
Acting Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019

Dear Acting Secretary Hargan:

Thank you for the opportunity to submit comments on the HHS Notice of Benefit and Payment Parameters for 2019. The undersigned organizations urge the Department to modify the proposal to better protect patients and ensure they will continue to have access to affordable and adequate health care coverage.

The eleven undersigned organizations represent millions of patients facing serious, acute, and chronic health conditions across the country. Our organizations have a unique perspective on what patients need to prevent disease, cure illness, and manage chronic health conditions. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge the Department to make the best use of the knowledge and experience our patients and organizations offer in response to this proposed rule.

In March 2017, our organizations agreed upon three overarching principles¹ to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need including the services in the essential health benefit package; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care. Enrollment should be easy to understand and benefits should be clearly defined.

Using these principles as our benchmark, our organizations are deeply concerned about many of the policies and changes included in the proposed rule and their potential impact on the communities we represent and serve. In the proposed rule, HHS and CMS recommend eliminating several standards that have served to protect patients and consumers, including those related to benefit structure, cost, and oversight. Based on our principles, our organizations strongly encourage HHS to modify the Notice of Benefit and Payment Parameters for 2019 (NBPP) in the final rule in the following areas:

Adequacy

Our organizations have agreed upon the principle that healthcare must be adequate, covering the services and treatments patients need, including those with unique and complex health needs. It is paramount that protections for these patients be preserved, including the essential health benefits (EHB) packages, the ban on annual and lifetime caps, and restrictions on premium rating. We are deeply

¹ Healthcare reform principles. American Heart Association website. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf

troubled by policy changes in the proposed rule that weaken patient protections and loosen healthcare coverage and quality standards. Our organizations emphatically urge the Department to improve upon the proposals in the final rule.

Essential Health Benefits (EHBs)

Our organizations are deeply concerned about the proposal to weaken the EHB requirements. Moves to destabilize these core patient protections by allowing states to mix and match benefit structures in a way that could harm patients are particularly worrisome.

Under the proposed rule, states would have more flexibility to select an EHB-benchmark plan. A state could:

- maintain its current EHB-benchmark plan;
- choose another state's EHB-benchmark plan, either in part or in whole;
- choose elements from EHB-benchmarks in multiple states; or
- select an entirely new EHB-benchmark plan so long as it is comparable to a "typical employer plan."

We are concerned that the flexibility allowed under this policy proposal could allow states to design benchmark plans that offer not just less generous coverage, but the *least* generous coverage of each of the ten EHBs available across the country. Under the proposed rule, other states could then duplicate these benchmark plans and subject even more Americans to limited or skimpy EHB coverage.

Pick another state's EHB benchmark

HHS is proposing to allow a state to choose another state's EHB-benchmark plan beginning in plan year 2019. We are concerned this policy will encourage states to drop or otherwise limit benefits. While the ACA requires plans to cover 10 essential health benefits, the extent of that coverage is dependent upon the chosen EHB benchmark plan. For example, fertility treatments are covered in more than half of states' EHB benchmark plans.² Under the HHS policy, a state whose benchmark currently requires coverage of fertility treatments could choose another state's policy that does not provide coverage. Thus, consumers who previously had coverage of fertility services could no longer have coverage of these services.

Pick and choose from other states' EHB benchmarks

HHS is proposing another option to allow a state to choose specific benefit categories from other states' benchmark plans. We are equally concerned this policy would result in the reduction of coverage of benefits and we encourage HHS to withdraw this proposal. Under this proposal, a state could pick-and-choose the least generous EHB-benchmark for each of the 10 EHB requirements. To the extent that a less generous benchmark is chosen, consumers will be forced to pay more out-of-pocket in order to obtain services that previously were covered.

Select a new benchmark plan

HHS is also proposing to allow states to define new benchmark plans. States currently have 10 benchmark plans to select from each year to help define that state's essential health benefits

² Essential health benefits: benchmark plan comparison 2017 and later. Cigna website. <https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf>. Published January 2017.

package. The current process provides state governments sufficient options and allows them to select plans that reflect the unique needs of populations within the state.

While the draft rule indicates that the goal is greater state flexibility, the broad flexibility proposed could easily translate into a reduction in benefits. States could replace any or all of the ten categories with the least generous corresponding category in another state's benchmark plan, eroding the value of the benefit and leading to increased patient out-of-pocket cost-sharing.

Allowing states to select benchmark plans from other states, or to select a benefit category from another state's benchmark plan runs counter to meeting the unique needs of beneficiaries in that state. Allowing states to cherry pick options would potentially allow states to reduce or weaken beneficiary benefits because states can find plans – and categories – anywhere in the country and select the least comprehensive suite of benefits to create scaled back coverage requirements.

New benchmark plans that curtail benefits will likely mean higher cost-sharing burdens and out of pocket expenses for patients. The problem is compounded because benefits that are not covered do not count towards out-of-pocket maximums.

Shifting Actuarial Value Between EHB Categories

In section 156.115, HHS proposes to allow plans to adjust their actuarial value (AV) between nine of the ten EHB categories (the proposal excludes the prescription drug category). By allowing plans to adjust the AV between categories, issuers could shift the generosity of the benefit to less frequently used categories. This provision could allow states to design plans with little or no coverage in a specific category, allowing them to strategically avoid certain types of patients. For example, a plan could shift AV away from behavioral health services into another category. As a result, access to services for patients with behavioral or substance use disorders, for example, would be restricted.

'Rehabilitation and Habilitation Services and Devices' is a particularly broad category of EHB that may be particularly vulnerable if the proposal is adopted. *Rehabilitative services* are provided to help a person regain, maintain, or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. *Habilitative services* are provided in order for a person to attain, maintain, or prevent deterioration of a skill or function *never learned or acquired* due to a disabling condition. Rehabilitative and habilitative services and devices include but are not limited to rehabilitation medicine, inpatient rehabilitation hospital care, physical and occupational therapy, speech language pathology services, behavioral health services, recreational therapy, developmental pediatrics, psychiatric rehabilitation, and psycho-social services provided in a variety of inpatient and/or outpatient settings.

Today, all of these therapies and needs can fall under the federal definitions of habilitative and rehabilitative services adopted in the 2015 Notice of Benefit and Payment Parameters, and qualified health plans have significant latitude in determining the type and amount of these various therapies to include in their interpretation of the category EHB requirement.³ If states enable health plans to change

³ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,871 (Feb. 27, 2015).

benefits both *within* and *across* EHB categories, less utilized types of rehabilitative and habilitative services could be among the first to be lost to enrollees.

Our patients have unique health needs. Limiting changes to AV within a category provides our patients a baseline of coverage in each category. Without this baseline in each category, patients could easily end up in a high metal tier plan that does not cover or severely limits coverage for their condition.

There are also broader market implications. Allowing plans to engage in adverse selection, weakens the stability of the marketplace. Our organizations encourage HHS to exclude this section from the final rule.

Lifetime and Annual Caps

Under current law, the ban on lifetime and annual caps only apply to EHB-covered services. In this proposal HHS would allow states to select plan structures that diminish the value of the EHB package, making them less meaningful. Therefore, this rule would once again subject patients to significant financial insecurity due to medical needs. In 2007 alone, more than 60 percent of all bankruptcies were the result of serious illness and medical bills.⁴ Heart transplants, specialty medications, complicated pregnancies, a cancer diagnosis, and most rare and complex conditions easily meet or exceed lifetime and annual caps so special attention should be given to the impact of this policy on patient populations. For example, prior to the ACA, many children with hemophilia would hit the lifetime limit on coverage under both parents' insurance plans before turning 18, leaving them without coverage options.⁵ For these reasons, we strongly caution HHS against including these policies in the final rule and stress the importance of maintaining adequate coverage for all patients regardless of geographical location.

Network Adequacy

In the Market Stabilization rule, HHS announced it would rely on states for Qualified Health Plan (QHP) certification related to network adequacy and essential community providers (ECPs).⁶ HHS now indicates that it will continue this policy for plan year 2019 and beyond.

While we agree with HHS that states should play a major role in the structure and management of their exchanges, we are concerned that continuing this policy may result in unequal access to important consumer protections. While some states may choose to enact strong network adequacy requirements and/or ECP policies – and devote significant resources to determining that issuers are complying with the requirements – others are not positioned to do so. In order to ensure consistency of network adequacy and ECP provisions, federal oversight is justly warranted. HHS has also not provided any evidence to suggest that a higher standard poses a challenge for issuers, which is concerning given the potential impact on patients' ability to access care.

We also caution HHS against including accreditation as a proxy for having met network adequacy requirements because not all accrediting entities provide certification specific for Exchange plans. In addition, while we are pleased the National Association of Insurance Commissioners' (NAIC's) Health Benefit Plan Network Access and Adequacy Model Act provides important consumer protections, we

⁴ Himmelstein DU, Thorne D, Warren E, Woolhandler S. Medical bankruptcy in the United States, 2007: results of a national study. *The American Journal of Medicine*. 2009.

⁵ Neubauer, B. No more 'lifetime limits' on insurance. *Grand Forks Herald*. December 22, 2009. <http://www.grandforksherald.com/opinion/columns/2115871-brenda-neubauer-bismarck-column-no-more-lifetime-limits-insurance>.

⁶ United States, Congress. Market stabilization, final rule. *Patient Protection and Affordable Care Act, 82 USC 18346*. April 18, 2017

note that this Model Act does not require quantitative standards (e.g., time and distance standards) and has not yet been widely adopted by states.

With respect to the proposed ECP policy, we urge HHS to withdraw its current proposal and impose a higher ECP standard, such as the 30 percent standard that was previously in effect. A stronger ECP standard will help to ensure that enrollees have access to in-network specialty hospitals, such as Children’s Hospitals, which provide vitally important pediatric oncology, cardiology, genetics, neonatal, and many other essential services. ECPs also include Federally Qualified Health Centers, which are key access points and serve one in every thirteen people.⁷ It is imperative that networks contain enough ECPs so that patients, particularly those with serious or chronic diseases, can access treatment services. HHS has also not provided any evidence to suggest that a higher standard poses a challenge for issuers. This is particularly concerning given the potential impact on patients’ ability to access care.

Medical Loss Ratio

The Minimum Medical Loss Ratio (MLR) provision of the Affordable Care Act established a single nationwide requirement that insurers spend at least 80 percent and 85 percent for individual and group health plans respectively, on medical care and quality improvement activities. Insurers who fail to meet these standards must rebate amounts in excess of those limits back to plan enrollees.⁸

When the measure took effect in 2011, it standardized the widely varying minimum MLRs then in effect in 34 states. Since that time, full implementation of the program has raised awareness and understanding of its benefit to policyholders as a powerful tool for promoting transparency, accountability, and value in health care costs in ways consumers can understand.

Several publications, including a recent *Health Affairs* blog, have noted the program’s significant success since its implementation, demonstrated by the reduction in total rebates returned to enrollees from over a billion dollars in 2012 to \$397 million in 2016.⁹ Moreover, in 2016 the average MLR for individual health plans was nearly 92 percent, and 86 percent in the small group market, exceeding the minimum requirements of the current regulations.¹⁰

We are concerned that the proposed changes to lower the current MLR requirements for insurers in their states in 2019 and beyond will increase enrollee’s out-of-pocket costs. In addition, we disagree with the premise that reducing the MLR will help to stabilize the individual markets; these markets would be better served by providing permanent funding for cost-sharing reduction subsidies and providing resources for a robust education and outreach plan to encourage as many individuals as possible – particularly younger individuals – to enroll in marketplace coverage. We strongly encourage the preservation of the MLR requirement in its current form.

⁷ Ibid.

⁸ Medical loss ratio. The National Association of Insurance Commissioners website. http://www.naic.org/cipr_topics/topic_med_loss_ratio.htm. Last updated March 15, 2017.

⁹ Jost T, Keith K. The 2019 proposed payment notice, part I: insurer and exchange provisions. Health Affairs Blog. <https://www.healthaffairs.org/action/showDoPubSecure?doi=10.1377%2Fhblog20171028.684065&format=full>. Published October 28, 2017.

¹⁰ 45 CFR 158

Affordability

Our organizations recognize that illness impacts both the rich and the poor. We believe that all patients, regardless of their economic situation, should be able to have the treatment they require and that healthcare should be affordable. Affordable healthcare coverage includes reasonable premiums and cost-sharing, including protecting those with pre-existing conditions from being charged more for their coverage. Unfortunately, the proposed policy does not achieve this aim. Our organizations encourage HHS to revise the proposal to protect patients from arbitrary or predatory rate increases.

Premium Review

Our organizations are further concerned about the proposed changes in “Part 154 – Health Insurance Issuer Rate Increases; Disclosure and Review Requirements.” The proposal, which would increase the threshold triggering a rate review from a 10 percent to a 15 percent increase, is deeply troubling.

Patients facing chronic conditions, including those represented by our organizations, require regular treatments to manage complex medical conditions. The first barrier to accessing needed treatment is having health insurance. Higher premiums can be devastating for all healthcare consumers. Without affordable, quality healthcare, patients with chronic illness will not have the treatment they need.

From 2017 to 2018, the average benchmark plan premium increased by 37 percent.¹¹ Higher premiums, even with Advanced Premium Tax Credits (APTC) make it more difficult for patients to purchase healthcare. For patients with chronic diseases, having health insurance is the reason they are able to access treatment to manage their disease. For example, a patient with asthma needs maintenance medication to prevent asthma exacerbations and costly trips to the emergency department. Healthcare needs to be affordable and adequate for patients, including patients who need a robust benefit.

The rate review process is the only protection consumers have from unnecessarily burdensome rate increases. It is important for all patients that premiums remain affordable. We urge the Department to keep the threshold at a 10 percent increase. Any increases above the 10 percent threshold are burdensome to patients.

Annual Out-of-Pocket Maximums

The ACA also implemented a requirement for Qualified Health Plans (QHPs) to include an annual out-of-pocket maximum set each year by HHS. For 2017, the annual out-of-pocket limit for an individual is \$7,150, and for a family plan is \$14,300.¹² Similar to the ban on annual and lifetime caps, the out-of-pocket maximums only apply to EHB-covered services.¹³

If HHS moves forward with these proposed allowances for states to dramatically weaken their EHB requirements, HHS will also be subjecting patients with complex and chronic conditions to unaffordable yearly cost-sharing. Under this proposal, a state could weaken their EHBs extensively enough to subject patients to unlimited cost-sharing for medically-necessary services they rely on.

¹¹ Health plan choice and premiums in the 2018 federal health insurance exchange. Health and Human Services website. <https://www.healthaffairs.org/action/showDoPubSecure?doi=10.1377%2Fhblog20171028.684065&format=full>. Published October 30, 2017.

¹² Out-of-pocket maximum/limit. Healthcare.gov website. <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/>.

¹³ United States, Congress. *Patient Protection and Affordable Care Act*, 42 USC 18001. Public law. 111-148. <https://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>. January 5, 2010.

Once again, we strongly urge HHS to abandon these proposals in the final rule, and ensure patients are protected from unaffordable cost-sharing requirements.

Accessibility

The third key principle agreed to by our organizations is that healthcare must be accessible. We have stated that, “All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods or lock outs through adequate open and special enrollment periods”. All patients need access to quality and affordable healthcare to manage chronic diseases and be able to access medical care during a health emergency and the connection between health insurance and health outcomes is clear and well documented.^{14,15} While we are pleased at some provisions included for special enrollment periods, we are still concerned that changes to other areas, including navigators, do not meet the goals of this principle. Some of the proposals would make it more difficult for patients to enroll in healthcare and thus less likely to have coverage when they need it most. Our organizations urge the Department to modify the policy proposal in the following ways.

Navigators

Navigators offer a critically important and unparalleled suite of services for enrollees. Navigators help people who need health insurance enroll through their state Exchange while also educating consumers about their coverage options, including Medicaid and Medicare.

Marketing, education, and outreach conducted by Navigators are essential to promoting a healthier, balanced risk pool, which benefits the entire market by bringing down the cost of insurance and stabilizing the markets.¹⁶ Patients and their families rely on Navigators as resources to find and attain adequate and affordable health care coverage through the most appropriate program. Reducing or scaling back support for these services poses a serious threat to the short- and long-term wellbeing of patients. Navigators are a critical bridge to accessing and understanding health care information and coverage for patients and consumers. As such, we are deeply concerned about CMS’s proposed policy change to scale back the Navigator program.

Standardized Plans

Our organizations are disappointed the proposed rule seeks to end the standardized health plan options for exchange consumers. These plan options allowed consumers to easily compare plan benefits and the costs associated with the plans. Creating more clarity in the marketplace will better allow patients to pick the plan that is right for them at the lowest possible cost. The standardized plans helped create a more educated consumer base to choose the plan that is right for their health needs. Our organizations strongly encourage HHS to reconsider abandoning this important consumer tool.

¹⁴ McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs*. 2004; 23(4): 223-233.

¹⁵ Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. *Medical Care Research and Review*. 2005; 62(1): 231-249.

¹⁶ Livingston, S. CMS slashes ACA marketplace education and outreach funds. *Modern Healthcare*. <http://www.modernhealthcare.com/article/20170831/NEWS/170839969>. Published August 31, 2017.

Special Enrollment Periods

Special Enrollment Periods (SEPs) provide a vital opportunity for individuals to obtain access to coverage when the consumer's circumstances change during the course of the year and we encourage HHS to ensure that consumers can use this pathway to obtain coverage. We support HHS' proposal to exempt from the prior coverage requirement individuals who live in an area in which no QHP was available. We are pleased that in plan year 2018, every county in the country had at least one issuer participating on the Exchange. We strongly encourage HHS to continue to work with issuers to ensure universal participation so that this proposed exemption is not necessary.

HHS also proposes a 60-day SEP for women who lose access to CHIP coverage for their unborn child. We strongly support this proposed change, which will allow women access to coverage through an Exchange. This policy also aligns with a similar SEP for termination of pregnancy-related Medicaid coverage.

Other Concerns

While we are pleased that some of the current regulatory framework, including important patient protections, is maintained in the proposal, we are concerned that the general shift away from federal authority and nationwide standards in favor of increased state oversight responsibility could result in weaker protection for patients.

Guided by the real experiences and needs of people with high health needs that we represent, many of our groups have collaborated with both federal and state authorities in implementing reforms designed to protect patients in health plan rules, programs, and systems. We are enormously grateful to those states and individuals who worked diligently to nurture new markets of comprehensive and affordable coverage suitable for people with pre-existing and complex conditions. It is our hope that they and others will continue to do so. However, we view recent advances in benefit design, transparency, and accountability, as well as protections against adverse selection and discriminatory practices, as vital safeguards that could be eroded over time as procedures are streamlined, functions are outsourced and public services are cut back.

For example, evolutions in the administration of prescription drug benefits including, requirements and standards for Pharmacy and Therapeutics Committees, pre-enrollment disclosure of formulary details and timely responses to exception and appeal requests require significant and detailed monitoring if they are to achieve and maintain their intended purpose.¹⁷ States lacking sufficient resources to support comprehensive monitoring will have to rely on issuers' submissions as proof of compliance with critically important protections and at the expense of vulnerable enrollees.

We view this shift as further evidence of a strategy highlighted by the October 12, 2017 Executive Order,¹⁸ that seems to discourage enrollment in QHPs in favor of less comprehensive coverage. We anticipate a trend toward greater confusion and less confidence in health insurance among our

¹⁷ Patient Protection & Affordable Care Act: HHS Notice of Benefit & Payment Parameters for 2016 NBPP Final Rule Sec (§ 156.122) , 80 Fed. Reg. 10750 (Feb. 25, 2014) (to be codified at§ 156.122.)

¹⁸ Presidential executive order promoting healthcare choice and competition across the United States. The White House website. <https://www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition>. Published October 12, 2017.

constituents as Navigator services, EHBs, stringent rate reviews, and network adequacy standards are rolled back. We fear many individuals and families will face increased costs as the individual and small group risk pools worsen over time, resulting in ever-increasing premiums and out-of-pocket costs.

Conclusion

Our organizations represent millions of patients who need access to quality and affordable healthcare regardless of their income or geographic location. We appreciate the opportunity to provide observations, analyses and recommendations on the proposed rule. However, we are deeply concerned that the rule could seriously undermine the key principles of access, adequacy, and affordability that are the underpinnings of current law -- the very principles that guide our member organizations today.

As leaders in the health care and research communities and staunch patient advocates, we look forward to working closely with HHS leadership and staff on the direction of such important public policy. Thank you for the opportunity to submit comments on this important rule. If you have any questions, please contact Katie Berge, AHA Government Relations Manager, at katie.berge@heart.org or 202-785-7909.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Arthritis Foundation
Crohn's & Colitis Foundation
Epilepsy Foundation
Family Voices
Lutheran Services in America
March of Dimes
National Multiple Sclerosis Society
National Organization for Rare Disorders

CC: The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services