

Harold P. Wimmer
National President and
CEO

December 11, 2017

The Honorable Randy Pate
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Director Pate:

The American Lung Association appreciates the opportunity to comment on the Draft 2019 Letter to Issuers in the Federally-facilitated Exchanges (FFE's).

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD. The Lung Association has significant expertise in lung diseases and the care required to manage them. The Lung Association encourages the Center for Consumer Information and Insurance Oversight (CCIIO) to focus on patients and how to help them obtain accessible, adequate and affordable health care as the agency provides guidance to issuers seeking to offer Qualified Health Plans (QHPs) in the FFEs.

The draft letter makes a number of references to HHS' proposed Notice of Benefit and Payment Parameters for 2019. The American Lung Association has already submitted comments on this proposed rule outlining our concerns with several changes, including those related to network adequacy, essential community providers and rate review (see attachments 1-3).

The draft letter also notes that open enrollment will begin on November 1, 2018. This year, the open enrollment period for the FFEs will run from November 1 to December 15, 2017, half the time offered for enrollment in the previous two cycles. The Lung Association encourages HHS to evaluate the 2017 open enrollment period compared to these previous

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enrollment cycles to see if a longer enrollment window in 2018 could better serve patients and results in a greater number of Americans signing up for coverage.

Thank you for the opportunity to offer our comments on these important issues.

Sincerely,

A handwritten signature in black ink that reads "Harold Wimmer". The signature is written in a cursive, flowing style.

Harold P. Wimmer
National President and CEO

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

The Honorable Eric D. Hargan, Acting Secretary
U.S. Department of Health and Human Services

Attachment 1

Harold P. Wimmer
National President and CEO

November 27, 2017

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

Dear Acting Secretary Hargan:

The American Lung Association appreciates the opportunity to comment on the HHS Notice of Benefit and Payment Parameters for 2019.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD. The Lung Association has significant expertise in lung disease and the care required to manage those diseases. In 2015, Lung Association staff co-authored "[Standards for Asthma Self-Management Education](#)" published in the Annals of Allergy and Clinical Immunology, and serves as the standard of practice.

Additionally, the Lung Association's Helpline has served as an enrollment assistor helping patients enroll in the marketplace. The Lung Association has also partnered with the Self-Made Health Network to educate navigators about tobacco surcharges and tobacco cessation.

The American Lung Association is committed to ensuring all patients are treated with guidelines-based care. Since 2008, the organization has tracked tobacco cessation coverage in state Medicaid programs and since 2016 the Lung Association has collected state Medicaid programs' coverage of guidelines-based asthma care. It is imperative that patients getting healthcare through the exchanges also have access to guidelines-based care. While state flexibility is important, the Lung Association urges the Department of Health and Human Services to make sure plans sold on the exchanges offer treatments, so providers can care for their patients according to the guidelines.

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In March of 2017 the Lung Association committed to a set of healthcare principles (see Appendix A). The principles state that any changes to the healthcare system must achieve healthcare that is affordable, accessible and adequate for patients. Unfortunately, some of the policy proposals detailed in the proposed Notice of Benefit and Payment Parameters for 2019 (NBPP) do not meet the standards that patients need. The American Lung Association requests that the Department modify the proposals in the final NBPP rule to ensure all Americans have quality and affordable healthcare.

Changes to the Essential Health Benefits (EHB)

The Lung Association is concerned the changes proposed in Section 156 of the rule will make healthcare coverage less robust for patients in the exchanges resulting in less adequate care. Since the lifetime and annual limits only apply to the EHB, if the definition of EHB changes with a decrease in coverage, these essential protections are lost. Many lung diseases, such as lung cancer, require innovative and expensive therapies, such as targeted immunotherapies, to survive. It is vital for our patients that their treatments are not subject lifetime or annual limits.

The proposal in section 156.111 would allow states to change their benchmark plans in one of three ways. While states would still be required to cover all 10 EHB categories, the Lung Association believes this could lead to a reduction of benefits offered as part of the EHB.

The first option states have is to change their benchmark plan and choose another state's benchmark plan. The Lung Association is concerned that this would encourage states to choose a plan with less generous benefits. For example, just less than half of 2017 benchmark plans cover bariatric surgery.¹ If this policy was adopted, states may choose a state benchmark with less generous benefits, reducing coverage for patients.

The second option would allow a state to select EHB categories from other states' benchmark plans. The Lung Association opposes this option. If a state were to pick and choose the 10 EHB categories from multiple other states, the Frankenstein-like state benchmark plan would not resemble a typical employer plan. This is not only contrary to the law, but also harmful to patients. There are no protections or guardrails that would maintain robust coverage that patients have under the current approach. The Lung Association urges the Department not to adopt this proposal in the final rule.

The third option would allow states to create their own benchmark plan as long as it resembles a typical employer plan. The Lung Association believes this approach is misguided and will result in harm to patients. The proposed rule loosely defines a "typical employer plan," but does not preclude high deductible or grandfathered plans from the definition. Patients in states that choose

¹"Essential Health Benefits: Benchmark Plan Comparison 2017 and Later," Cigna, January 2017, available at <https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf>.

less generous benchmark plans could face higher out-of-pocket costs, fewer protections in terms of annual and lifetime limits and less coverage in general.

In the past few years, states have increasingly reduced coverage in their state Medicaid programs, under the guise of controlling costs. For example, Massachusetts recently submitted an 1115 waiver that would allow for the creation of a closed formulary with a floor of one drug per class, which would severely limit the robustness of the coverage provided. The Lung Association believes this pattern of reducing benefits would continue with the benchmark plans. The Department admits that “consumers who have specific health needs” may be adversely impacted by this proposal. “Depending on the selections made by the state in which the consumer lives, consumers with less comprehensive plans may no longer have coverage for certain services.”² Lung disease patients have specific health needs and their lives depend on their treatments. The Lung Association urges the Department not to adopt this proposal in the final rule.

Shifting Actuarial Value

In section 156.115, the Department proposes to allow plans to adjust the 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, the Lung Association fears plans may shift the generosity of the benefit to less used categories. This provision could be used to encourage sicker patients to not choose the health plan due to the lack of benefits the plan offers. For example, a plan could weaken coverage categories for consumers with high medical needs and costs in an attempt to only attract healthy and inexpensive consumers. Lung disease patients could see fewer plans covering the treatment they need, decreasing healthcare coverage options.

There are also broader market implications by allowing plans to adjust the AV value and create an adverse selection in the marketplace, including weakening the stability of the marketplace. The Lung Association requests the Department to remove this section from the final rule.

Premium Review

The Lung Association is concerned about the proposed changes in *Part 154 – Health Insurance Issuer Rate Increases; Disclosure and Review Requirements*. The proposal to increase the threshold triggering a rate review from a 10 percent increase to a 15 percent increase is deeply troubling.

Many lung disease patients, including those with asthma, COPD and lung cancer require regular treatments to manage complex medical conditions. The first barrier to accessing needed treatment is having health insurance. Increasing premiums can be devastating for these patients and lead to some patients going without health coverage. Without affordable, quality healthcare, patients with lung disease will not have the treatment they need, resulting in poor health outcomes or death.

² Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 82 Fed. Reg. 51313 (Nov 2, 2017). Available at: <https://www.gpo.gov/fdsys/pkg/FR-2017-11-02/pdf/2017-23599.pdf>

From 2017 to 2018, the average benchmark plan premium increased by 37 percent. Increasing premiums, even with Advanced Premium Tax Credits (APTC), pose a burden for patients to purchase healthcare coverage. For patients with lung disease, having health insurance allows access to treatment to manage their disease. For example, a patient with asthma needs maintenance medication to prevent asthma exacerbations. For patients with lung cancer, the ability to afford health insurance is literally a matter of life and death. Healthcare needs to be affordable to patients, including patients who need a robust benefit.

The rate review process is the only consumer protection from unnecessarily burdensome rate increases. For lung disease patients who depend on medical treatment to breathe, it is important that premiums remain affordable. The Lung Association urges the Department to keep the threshold at a 10 percent increase. Increases above the 10 percent threshold are burdensome to patients and the Department has a responsibility to ensure the increases are legitimate and protect patients from arbitrary rate increases.

Enrollment Navigators

Section 155.210 and Section 155.215 reduce the number of state navigators from two per exchange to one per exchange. Additionally, these sections would remove the requirement that one of the two navigators be a community and consumer focused non-profit. The section also removes the requirement that at least one of the navigators have a physical presence. The Lung Association believes this is misguided and will harm patients and urges the Department not to include this provision in the final rule.

The Lung Association has collaborated with local enrollment navigators through a partnership with the Self-Made Health Network to help educate navigators about the tobacco surcharge and tobacco cessation resources. Through this partnership, the Lung Association has worked closely with the navigators and has seen the benefits of having community-based organizations engaged in face-to-face interactions with consumers. Navigators serve as liaisons to their community and have the ability to address and help consumers overcome modifiable barriers to sign up for healthcare.

Navigators play an important role in helping consumers obtain consistent access to comprehensive health insurance through publicly-funded programs such as Medicaid but also in helping them to remain consistently insured. Navigation services are ideal to address many of the health disparities associated with diversity, literacy and culture because they foster a sense of trust and empowerment within the communities they serve.³ Lung disease patients are part of these communities served by navigators. For example, almost half of children living with asthma are on the Medicaid program.

³ Natale-Pereira A, Enard KR, Nevarez L, Jones LA. The Role of Patient Navigators in Eliminating Health Disparities. Cancer. 2011;117(15 0):3543-3552. doi:10.1002/cncr.26264.

Over the years, patient navigation has continued to evolve and is recognized as an effective means to facilitate access to quality medical care (including preventive care services) by identifying and bridging gaps in understanding and encouraging compliance, thereby reducing barriers to care.⁴ The patient navigator program helps all patients, including those with lung disease, access quality and affordable care. The community-based, in-person navigators are vital to the continued success of the program and the healthcare marketplace in general. The Lung Association urges the Department to remove this provision in the final NBPP rule.

Medical Loss Ratio (MLR) Standards

Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirement, proposes changes to the MLR. The MLR is a key patient protection to ensure that between 80 and 85 percent of premium dollars go towards patient care and not towards profits for insurance companies. Currently insurance companies have to provide documentation that they are spending the correct percentage of premium dollars on patient care; if not, patients receive a rebate. The proposed rule, in section 158.221, allows insurance companies to report a MLR of 80 percent rather than “report the issuer’s actual expenditures for actives to improve health care quality”.

The American Lung Association is very troubled by this proposal. Without reporting the issuer’s actual expenditures, there is no way to verify the 80 percent MLR. This is harmful to lung disease patients as it could result in increased premiums with less healthcare delivered, as issuers would no longer have to document meeting the 80 percent MLR. This provision has had great success. In 2012, consumers received over a billion dollars in rebates; however, in 2016, consumers only received \$397 million in rebates.⁵ By requiring the reporting of actual expenditures and reimbursement to consumers, this provision has led issuers to change their behavior. If the requirement of reporting actual expenditures is removed, this would result in higher premiums than are necessary for the care that patients received.

This section also provides an option for states to establish their own MLR. The Lung Association opposes this proposal. If a state wants to waive the 80 percent MLR they should seek to waive it through the 1332 waiver process and provide evidence that it will not increase premiums or reduce coverage, per the statutory requirements of the 1332 waiver process.⁶

⁴ Moy B, Chabner BA. Patient Navigator Programs, Cancer Disparities, and the Patient Protection and Affordable Care Act. *The Oncologist*. 2011;16(7):926-929. doi:10.1634/theoncologist.2011-0140.

⁵ “The 2019 Proposed Payment Notice, Part 1: Insurer And Exchange Provisions, ” Health Affairs Blog, October 28, 2017.DOI: 10.1377/hblog20171028.684065

⁶ United States Congress. *Patient Protection and Affordable Care Act, 42 USC 18001*. Public law. 111-148. <https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>. January 5, 2010.

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).⁷ The Department now indicates that it will continue this policy for plan year 2019 and beyond.

The Lung Association agrees with the Department that states should play a role in the structure and management of their exchanges; however, 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 – not all states are positioned to do so. In order to ensure consistency of the network adequacy and ECP provisions, federal oversight is warranted.

The Lung Association urges the Department to establish higher standards for ECPs. Lung disease disproportionately impacts low-income populations and it is critical those patients are able to see providers in their communities that are accessible to them.

Minimum Essential Coverage

The Department asks for comment on whether Medicaid Buy-In programs should be designated as Minimum Essential Coverage (MEC) without submitting an application. The Lung Association urges the Department to allow Medicaid Buy-In programs that provide benefits equivalent to the VIII group to be automatically designated as MEC. In an effort to stabilize the marketplace and increase competition, the Lung Association believes states should have the flexibility to offer a Medicaid Buy-in program.

Other Considerations

The American Lung Association believes all patients should have access to quality and affordable care that allows for guidelines-based treatment. As such, we urge the Department to ensure coverage for asthma care, tobacco cessation and other diseases cover the necessary treatments so providers can furnish guidelines-based care to their patients.

To ensure patients have guidelines-based care, benchmark plans should cover the National Asthma Education and Prevention Program (NAEPP) guidelines, including robust medications coverage. Tobacco is leading cause of preventable death in the United States and quitting smoking is the single best thing a person can do for their health. To save both money and lives, the Lung Association strongly encourages benchmark plans to cover a tobacco cessation benefit modeled off of the Public Health Services Treating Tobacco Use and Dependence Clinical Practice Guidelines

⁷ Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 18346-18382 (April 18, 2017). <https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization>

2008 Update and the United States Preventive Services Task Force (USPSTF) 2015 Recommendation. This can be achieved by modeling the benefit on the Federal Employee Health Benefits plan's cessation benefit.⁸

Lastly, there are many treatments receiving an "A" or "B" by the USPSTF that are prescription drugs and appear on a formulary. The Lung Association strongly encourages the Department to incentivize issuers to create formularies with a \$0 co-pay tier, as these preventive services medications are not subject to cost-sharing. This simple designation would add clarity for consumers, including smokers who are trying to quit.

The American Lung Association appreciates the opportunity to submit comments on this important rule and urges the Department to keep patients in the forefront when creating new policies that impact the accessibility, adequacy and affordability of healthcare.

Sincerely,

A handwritten signature in black ink that reads "Harold Wimmer". The signature is written in a cursive, flowing style.

Harold P. Wimmer
National President and CEO
American Lung Association

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

⁸ Office of Personnel Management. Federal Employee Health Benefits: Special Initiatives: Quit Smoking. Found at: <https://www.opm.gov/healthcare-insurance/special-initiatives/quit-smoking/>

Appendix A



Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all.

In addition, any reform measure must support a health care system that provides affordable, accessible and adequate health care coverage and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

Health Insurance Must be Affordable – Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must be Accessible – All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must be Adequate and Understandable – All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.

Attachment 2

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

Attachment 3



November 27, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on *HHS Notice of Benefit and Payment Parameters for 2019* Proposed Rule,
RIN 0938-AT12

Dear Administrator Verma:

We, the 138-undersigned patient and community organizations representing millions of patients and their families, are pleased to submit comments on the proposed rule, *Notice of Benefit and Payment Parameters for 2019* (Proposed Rule) (82 FR 51052, November 2, 2017).

I Am Essential is a broad coalition dedicated to the advancement of quality, comprehensive, and affordable health care for patients, many of whom have serious and/or chronic health conditions. Our comments reflect the needs of these beneficiaries and their experiences in shopping for and utilizing the Qualified Health Plans (QHPs) over the past several years. The comments primarily focus on the need of patients to access a broad array of health benefits and services contained in the “essential health benefits” with a particular focus on prescription medications, which are truly “essential” for our patients’ well-being.

We compliment the Department of Health and Human Services (HHS) for maintaining critical patient protections previously promulgated, but are very concerned that the proposed changes to how states can select their essential health benefits will diminish patient care and increase beneficiary’s out of pocket costs. Therefore, we urge HHS to maintain the current process for states to select their essential health benefits.

Due to the need of patients to access a wide array of health benefits and services, **we also are very concerned with the possibility that HHS might propose in the future a “Federal default definition of essential health benefits” which would include a “national prescription drug benefit standard.”**

We are also disappointed that HHS is abandoning the “standardized plan option” in the federally-facilitated market. Such plans are working well in many states, and allow beneficiaries to access benefits with set co-pays and often exempt prescription drugs from the deductible or have a separate, lower prescription drug deductible. We also oppose the proposed abandonment of the “meaningful difference” standard.

We reiterate our strong support of including prescription drug utilization in the Risk Adjustment Model. Despite the ACA’s goal to end discrimination based on pre-existing conditions, many health insurance plans currently engage in practices that enable them to avoid patients with serious and chronic conditions. We believe that compensating issuers through mechanisms like risk adjusters for their enrollees who need and use higher-cost prescription medications will encourage issuers to take responsibility for caring for these patients, remove incentives for avoiding the sickest patients, and reduce discriminatory practices that prevent vulnerable populations from accessing care and treatment. **We look forward to any reports HHS may conduct on the operation of the risk adjustment model after its first year of operation with prescription drug utilization data included.**

We appreciate your consideration of our insights and concerns as we all work to improve the patient experience and health outcomes under the ACA, particularly for those with serious and chronic health conditions.

Proposed New Options for States to Develop “Essential Health Benefits”

We are concerned with the proposal to provide states additional flexibility in defining a state’s “essential health benefits” by allowing additional options from which they can choose. **While the stated goal is “state flexibility,” having an almost endless combination of services creates the opportunity to reduce beneficiary health benefits and increase patient out of pocket cost-sharing. We urge HHS to abandon the proposed options and maintain the current process for states to select their essential health benefits.**

States currently have 10 benchmark plans to select from each year to help define that state’s essential health benefits package. We believe the current system best meets the ACA legal requirement that the essential health benefits be similar to a typical employer plan operating in the state. The current process provides states sufficient options and reflects the individual needs of the state. In fact, 7 out of the 10 benchmarks from which they can currently select are state-specific plans. Additionally, states can select from the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment.

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 needs of beneficiaries in that state. Constructing the benchmark plan by cherry picking benefit categories will create a plan that does not resemble any existing plan in the marketplace today. These options would 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. This would particularly be true for the proposed third option, which allows a state to create a new benchmark plan from scratch that must be less generous than the most generous

among a set of comparison plans. These proposals for selecting benchmark plans and categories will discourage states from offering comprehensive coverage because they would be responsible for defraying the costs beyond a minimal threshold of benefits.

New benchmark plans that curtail benefits will mean higher cost-sharing burden 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. Despite our concerns with the proposals surrounding the benchmark and categories, we are pleased that the Proposed Rule notes that if a plan covers drugs beyond the number of drugs covered by the benchmark, all of these drugs are essential health benefits and must count towards the annual limitation on cost sharing.

Future Proposal to Develop a “Federal default definition of essential health benefits”

We are surprised that at the same time as HHS proposes increased flexibility for states to select their essential health benefits, HHS is also considering developing a “Federal default definition of essential health benefits,” which could include a “national benchmark plan standard for prescription drugs” and thereby limiting state flexibility. **Since we have no information on how these national standards would be developed, we are concerned that this would lead to limits in beneficiary benefits and increased patient cost-sharing.** States would still be able to select a different benchmark, but they would have to defray the costs that exceed the Federal default. **This certainly raises a red flag that the “Federal default” under consideration would not be expansive and meet the needs of people living with serious and chronic conditions.**

We note that HHS has previously created certain federal requirements that plans must follow in their plan design regarding prescription drugs. The biggest problems patients are encountering are that some plans are not covering the drugs necessary for beneficiaries to manage their conditions and maintain their quality of life, and that many issuers have extremely large deductibles and very high co-insurance that make it difficult or impossible for beneficiaries to afford their medications. As we discuss below, if the current patient protections are followed and properly enforced, beneficiaries should be able to access their medications and maintain their health and quality of life.

Efforts to create a “national benchmark plan standard for prescription drugs” could lead to the creation of a national formulary. **We strongly oppose a national formulary because this approach would limit access to only a select list of drugs, fail to include new innovative drugs, ignores the individual healthcare needs of people with serious and chronic conditions, and limits provider options when treating their patients.**

Proposal to Abandon Standardized Plan Options & Meaningful Difference Standards

We are disappointed that HHS is proposing to abandon the Standardized Option (Simple Choice plans), and urge the Department to reconsider this proposal. Several states that run their own marketplace have successfully implemented standard plans and while we did not fully support all elements of the federal marketplace “Simple Choice plans,” its basic structure can be useful to beneficiaries.

We believe that consumers can benefit from being able to more easily compare plans across issuers and have some level of protection through cost-sharing limits, particularly for prescription medications, and exempting drugs in most metal levels from the deductible. Deductibles and other patient cost-sharing have increased to such a point that accessing health care, and particularly prescription medications, is becoming almost impossible for many patients. The use of standardized plans can help reduce the cost-sharing burden for patient and allow them to actually utilize their health insurance.

We do not share the Department's concerns that standardized plans stifle innovation because there is no requirement that issuers offer them and issuers are allowed to offer other plans.

We also oppose the proposal to abandon the “meaningful difference standard.” Shopping and selecting a plan that best meets a patient's health needs and which they can afford is not an easy process. Ensuring that plans are in fact meaningfully different reduces confusion and helps improve the beneficiary shopping experience. We disagree with the Department's assertion that the current “meaningful difference standard” limits innovation and believe the existence of such standards encourages greater innovation and differences among plans.

Maintaining and Enforcing Patient Protections

As stated in the Proposed Rule, the Affordable Care Act contains many important patient protections that help in defining essential health benefits and that all issuers must abide to when designing plan benefits. For example, plans must offer all ten categories of the essential health benefits, the benefits must be equal in scope to a typical employer plan, there has to be an appropriate balance across all categories, and plan benefit design cannot discriminate based on an individual's age or disability. The essential health benefits must also consider the health needs of diverse segments of the population including women, children, persons with disabilities, and other groups.

In previous regulation, HHS has further defined essential health benefits. For example, for prescription medications, every plan must cover at least the greater of one drug per class or the same number of drugs in each category and class as the state's benchmark plan. Previous regulation also requires plans to be transparent in their coverage of benefits and costs, utilize Pharmacy and Therapeutic Committees, and consider newly approved medications and treatment guidelines. Plans must also not limit delivery of medications to only mail order. Additional regulations have been promulgated to implement Section 1557 of the ACA, which further defines discrimination in healthcare. HHS has also provided examples of discriminatory benefit design to include excessive patient cost-sharing, excessive utilization management techniques, such as prior authorizations, and placing every drug to treat a certain condition on the highest tier.

As we wrote in a letter to HHS earlier in the year, continuation of these patient protections is critical so that qualified health plans meet the needs of patients, particularly those with serious and chronic conditions. We thank HHS for recognizing their importance by maintaining them and trust that in the expected *Letter to Issuers for 2019* other plan standards and expectations are maintained.

Patient protections are meaningless without proper enforcement. Despite the law or regulation, some insurers still design plans that are discriminatory and limit patient access. Beneficiaries continue to encounter plans that lack meaningful formulary coverage for prescription medications, engage in adverse tiering, have high cost-sharing and burdensome utilization management requirements such as extensive and/or unwarranted prior authorization and step therapy requirements. Beneficiaries also still face midyear formulary changes, and can have their medications switched for non-medical reasons. Current regulations and guidelines must be enforced.

We are concerned that in an effort to provide greater state flexibility, some states will not enforce these important patient protections, eroding beneficiaries' access to quality healthcare. Many states lack the financial resources and/or legal authority to prospectively review plans and formularies to ensure that they are adequate and do not discriminate against beneficiaries. Some states have stated they have no interest in or a limited capacity to implement plan requirements included in the ACA, including the important patient protections.

Therefore, we encourage HHS to fully enforce the patient protections contained in the law and in regulation, and ensure that if oversight and enforcement responsibilities are assumed by the states, they have the authority and resources necessary to fully address patients' protections, particularly non-discrimination in plan benefit design.

Thank you very much for your consideration of our comments. Should you have any questions, please contact: Carl Schmid, Deputy Executive Director, The AIDS Institute, cschmid@theaidsinstitute.org; Beatriz Duque Long, Senior Director, Government Relations, Epilepsy Foundation, bduquelong@efa.org; or Andrew Sperling, Director of Federal Legislative Advocacy, National Alliance on Mental Illness, asperling@nami.org.

Sincerely,

ADAP Advocacy Association
Adult Congenital Heart Association
AIDS Action Baltimore
AIDS Alliance for Women, Infants,
Children, Youth & Families
The AIDS Institute
Allergy & Asthma Network
Alliance for Aging Research
Alpha-1 Foundation
American Association on Health and
Disability
American Autoimmune Related Diseases
Association
American Behcet's Disease Association
(ABDA)

American Lung Association
Arthritis Foundation
Asian & Pacific Islander American Health
Forum
Association for Ambulatory Behavioral
Healthcare
Association of Nurses in AIDS Care
Brian Injury Alliance of Iowa
Bronx Lebanon Hospital Family Medicine
California Chronic Care Coalition
California Hepatitis C Task Force
Cancer Support Community
Caregiver Action Network
Children's Dental Health Project Phone
Number

CHOW Project
 Christopher and Dana Reeve Foundation
 Chronic Disease Coalition
 Coalition on Positive Health Empowerment
 (COPE)
 Community Access National Network
 (CANN)
 Community Catalyst
 Community Health Charities Phone Number
 Consumers for Quality Care
 Depression and Bipolar Support Alliance
 Digestive Disease National Coalition
 Dystonia Medical Research Foundation
 Easter Seals Massachusetts
 Epilepsy California
 Epilepsy Foundation
 Epilepsy Foundation Central & South Texas
 Epilepsy Foundation Houston/Dallas-Fort
 Worth/West Texas
 Epilepsy Foundation Long Island
 Epilepsy Foundation New England
 Epilepsy Foundation Northwest
 Epilepsy Foundation of Alabama
 Epilepsy Foundation of Arizona
 Epilepsy Foundation of Colorado
 Epilepsy Foundation of Connecticut, Inc.
 Epilepsy Foundation of Delaware
 Epilepsy Foundation of Eastern
 Pennsylvania
 Epilepsy Foundation of Florida
 Epilepsy Foundation of Georgia
 Epilepsy Foundation of Hawaii
 Epilepsy Foundation of Illinois
 Epilepsy Foundation of Indiana
 Epilepsy Foundation of Kentuckiana
 Epilepsy Foundation of Metropolitan New
 York
 Epilepsy Foundation of Michigan
 Epilepsy Foundation of Mississippi
 Epilepsy Foundation of Missouri & Kansas
 Epilepsy Foundation of Nevada
 Epilepsy Foundation of New Jersey

Epilepsy Foundation of North/Central
 Illinois, Iowa, Nebraska
 Epilepsy Foundation of Oklahoma
 Epilepsy Foundation of Utah
 Epilepsy Foundation of Vermont
 Epilepsy Foundation of Western Wisconsin
 Epilepsy Foundation of Wisconsin
 Epilepsy Foundation of Northeastern New
 York
 Epilepsy-Pralid, Inc.
 GBS | CIDP Foundation International
 GLMA: Health Professionals Advancing
 LGBT Equality
 HealthyWomen
 Hemophilia Association of the Capital Area
 Hemophilia Federation of America
 Hep Free Hawaii
 Hepatitis C Allies of Philadelphia
 (HepCAP)
 HIV Medicine Association
 Immune Deficiency Foundation (IDF)
 International Foundation for Autoimmune &
 Autoinflammatory Arthritis (IFAA)
 International Pain Foundation
 Interstitial Cystitis Association
 Lakeshore Foundation
 Latino Commission on AIDS
 Lupus and Allied Diseases Association, Inc.
 Lupus Foundation of America
 Lupus LA
 Men's Health Network
 Mental Health America
 METAvivor Research & Support, Inc.
 MLD Foundation
 NAMI Colorado
 NAMI North Carolina
 Nashville CARES
 NASTAD
 National Alliance on Mental Illness
 National Alopecia Areata Foundation
 National Association of Hepatitis Task
 Forces

National Association of Nutrition and Aging
 Services Programs (NANASP)
 National Black Women's HIV/AIDS
 Network
 National Consumers League
 National Council for Behavioral Health
 National Hemophilia Foundation
 National Hispanic Medical Association
 National Multiple Sclerosis Society
 National Native American AIDS Prevention
 Center (NNAAPC)
 National Organization for Rare Disorders
 (NORD)
 National Pancreas Foundation
 National Patient Advocate Foundation
 National Puerto Rican Chamber of
 Commerce
 National Community Pharmacists
 Association (NCPA)
 NeedyMeds
 NephCure Kidney International
 New Jersey Association of Mental Health
 and Addiction Agencies, Inc.
 Ovarian Cancer Research Fund Alliance
 Parent Project Muscular Dystrophy (PPMD)
 Partners for Better Care

Prevent Blindness
 Preventive Cardiovascular Nurses
 Association
 Project Inform
 Pulmonary Hypertension Association
 Reflex Sympathetic Dystrophy Syndrome
 Association
 Rush to Live Org
 Scleroderma Foundation
 Spina Bifida Association
 Susan G. Komen
 The Hepatitis C Mentor and Support Group
 The MAGIC Foundation
 The Marfan Foundation
 The Michael J. Fox Foundation for
 Parkinson's Research
 The Myositis Association Phone Number
 The Prevent Cancer Foundation
 The Veterans Health Council
 U.S. Hereditary Angioedema Association
 U.S. Hispanic Chamber of Commerce
 Unity Wellness Center
 U.S. Pain Foundation, Inc
 Usher 1F Collaborative, Inc
 Vietnam Veterans of America
 Virginia Hemophilia Foundation

cc: Randy Pate/CCIIO