



November 27, 2017

Submitted via the Federal eRulemaking Portal

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9930-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Re: RIN 0938-AT12 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019**

To Whom It May Concern:

We are writing on behalf of the Chronic Illness and Disability Partnership (CIDP). CIDP consists of national organizations representing individuals living with a wide range of chronic illnesses and disabilities, including cancer, diabetes, cerebral palsy, HIV, Hepatitis B and C, and mental health and substance use disorders. We represent the 117 million Americans estimated to be living with a chronic illness and/or disability, many of whom rely upon the Marketplaces to obtain needed care.<sup>1</sup> While our organizations are national in scope, we also affiliate with strong regional, state, and community based advocacy networks. We appreciate the opportunity to provide comments to the proposed Notice of Benefit and Payment Parameters for 2019.

Robust, federally enforced consumer protections and standards are essential for ensuring that people living with chronic illnesses and disabilities can access the medically necessary care and treatment they need through the Affordable Care Act's (ACA) Marketplaces. In modifying existing regulations and crafting new rules that govern the Marketplace, HHS should take this vulnerable population into account. We urge HHS not to weaken the ACA's critical consumer protections with this proposed rule and to consider the comments and recommendations detailed below.

---

<sup>1</sup> U.S. Centers for Disease Control and Prevention, Chronic Disease Overview (February 23, 2016), available at <https://www.cdc.gov/chronicdisease/overview/>.

### **Rate Increases Subject to Review (§ 154.200)**

We strongly oppose reducing the threshold for review of unreasonable premium increases from 10 to 15 percent. While we recognize that premiums have been increasing significantly, much of this has to do with uncertainty created by the past years' events. Insurers have cited uncertainty related to the Administration's ambivalence with respect to cost-sharing reduction subsidies and enforcement of the individual mandate as primary drivers of rate increases for the 2018 plan year.<sup>2</sup> Instead of seeking solutions to control the growth of health care and premium costs, this proposal would normalize even higher rate increases. While HHS should continue to work to stabilize the Marketplaces to avoid high premium increases, conceding to insurers' profit incentive is not the way to approach this problem.

While the proposed rule states that this change is in an effort to promote state flexibility, lowering the threshold for rate justification does not promote this objective. As noted in the proposed rule, some states impose stricter standards than the 10 percent threshold set by HHS, and may continue to do so as HHS will continue to set a minimum threshold. Thus, raising the federal floor for what constitutes a reasonable rate increase only signals to insurers that higher rate increase are acceptable at a time when HHS should seek to control premium growth. We urge HHS to reconsider this proposal and maintain current practice.

### **Standardized Options (§ 155.20)**

We strongly oppose eliminating the standardized plan options for the 2019 plan year and beyond. The standardized plans simplified the enrollment process for consumers, allowing them to make easier and more informed choices. The standardized options offered during the 2017 and 2018 plan years allowed consumers to more easily make apples-to-apples comparisons of plans and encouraged consumers to select plans based on the comprehensiveness of coverage and not solely based on premium price. This is particularly important for those living with chronic conditions for whom assessing plans for adequate coverage is already burdensome.

Further, standardized plan options help to restrict insurers' ability to manipulate actuarial value to produce discriminatory benefit designs that discourage enrollment by individuals with higher-cost chronic health conditions.<sup>3</sup> By restricting the flexibility to set differential cost-sharing amount for certain items and services, standardized options encourage plans to compete based on the generosity of other plan design elements, such as by providing more robust provider networks and formularies. Encouraging competition along these metrics will improve access to specialists and medications that treat chronic conditions.

---

<sup>2</sup> S. Corlette, *Proposed Premium Rates for 2018: What do Early Insurance Company Filings Tell Us?*, (May 17, 2017) <http://chirblog.org/proposed-premium-rates-for-2018-what-do-early-filings-tell-us/>.

<sup>3</sup> D. Jacobs, *CMS' Standardized Plan Option Could Reduce Discrimination*, Health Affairs Blog (January 6, 2016) <http://www.healthaffairs.org/do/10.1377/hblog20160106.052546/full/>.

Instead, this proposal erodes the strides made in streamlining the plan assessment and enrollment process and would eliminate standard options altogether, removing incentives for insurers to improve the quality of their offerings. We urge HHS to maintain and strengthen the standardized plan options, such as by considering standard options that utilize co-payments instead of co-insurance for specialty medications.

**Standards for Navigators and Certain Non-Navigator Assistance Personnel (§§ 155.210 and 155.215)**

The Navigator program has ensured that people living with chronic health conditions have access to the assistance and information they need to be able to understand their options and select the plan that is best suited for their particular health needs. We urge HHS to continue investing in this important program, including by fully funding the program moving forward and by incentivizing outreach to vulnerable populations.

We strongly oppose the proposal to remove the requirement that each Marketplace must have at least two Navigator entities, one of which is a community and consumer-focused nonprofit. Similarly, we urge HHS to maintain the requirement that Navigator entities maintain a physical presence in the Marketplace service area. Locally present organizations that have ties to the community are critical to ensuring that populations with the greatest need for Navigator support are identified and reached. While web-based brokers and assistance platforms have been growing in popularity, web-based assistance is not accessible to everyone, such as older or lower-income individuals that may have limited access to the internet. Additionally, web or phone-based assistance is a poor substitute for in-person assistance delivered by a known and trusted community-based organization. This is particularly true for those living with significant health needs for whom remote assistance may prove inadequate and frustrating. The ability to discuss particularized and sometimes sensitive health needs requires direct, face-to-face communication in a confidential space that web or phone-based assistance cannot provide.

Given the disruption and confusion caused by the uncertainty surrounding the future of the ACA, impartial and accurate information about open enrollment periods, subsidy programs, and coverage options are critical. In-person community-based organizations are best suited to deliver this information and undertake the robust consumer outreach necessary to ensure the continued success of the Marketplaces.

**Eligibility Determinations for Exchange Participation and Insurance Affordability Programs (§ 155.305)**

We strongly oppose the proposal to remove the requirement that direct notification must be sent to the tax filer informing them that eligibility will be discontinued due to failure to file a tax return and reconcile advance premium tax credits (APTC) received before discontinuing eligibility. Given recent instability, consumers may be confused about their obligations with respect to APTCs. Removing this requirement increases the potential for treatment interruptions due to coverage lapses, disrupting treatment regimens already in place. This is particular of particular concern for those living with chronic health conditions, as interruptions in treatment may have lasting negative consequences.

Relying on a general notice that APTC eligibility may be discontinued, without giving consumers the specific reason and thus directing them to corrective action, is insufficient to ensure that those wishing to continue their eligibility have the information necessary to do so. As noted in the proposed rule, 40 percent of households receiving this general notice did not take the appropriate action, demonstrating the lack of clarity this approach creates among consumers. It is unacceptable to continue to allow these consumers to lose their access to affordable coverage by not providing direct notification and affording consumers a meaningful opportunity to take the appropriate corrective action.

### **Special Enrollment Periods (§ 155.420)**

As we stated in our comments to the Market Stabilization rule earlier this year, we oppose further restricting the availability of special enrollment periods (SEPs). SEPs are vitally important to ensure that consumers both healthy and sick can access mid-year coverage options under the appropriate circumstances. Creating burdensome documentation requirements before someone may enroll in a plan through an SEP, particularly absent any documented evidence of consumers abusing SEPs, will only serve as an enrollment barrier for individuals who in fact have had a qualifying life event but cannot produce documentation in the short timeframe required. In particular, we urge HHS to reconsider its approach to SEPs in two ways.

First, we believe that individuals should have the ability to change between metal levels using an SEP. This is particularly important for some qualifying life events that result in increased or modified health needs. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. These life changes may alter the amount of advance premium tax credit an enrollee receives, substantially changing the affordability of various plan designs. Consumer choice is critical in ensuring that individuals are enrolled in the plan that will best meet their treatment and affordability needs. This is especially true for people living with chronic illnesses and disabilities for whom appropriate plan choice is critical to affordable health care access. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable.

Second, we continue to oppose continuous coverage requirements as a pre-condition of SEP availability. Life circumstances will inevitably result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll through an SEP when they meet all other criteria. We understand the need to ensure that the risk pools are balanced between healthy and sick individuals. However, we believe that the best way to do that is to invest in enrollment, education, and outreach activities and to ensure a strong risk adjustment program, not to penalize individuals suspected of being higher cost to plans.

Finally, we note as we did in our comments to the Market Stabilization rule that limiting plan metal level changes during SEPs and requiring evidence of continuous coverage are prohibited by statute. The guaranteed issue provision of the ACA requires issuers to “accept every employer and individual in the

State that applies for such coverage.”<sup>4</sup> While issuers “may restrict enrollment . . . to open or special enrollment periods,” this does not permit any restrictions on the type of plan enrolled in, nor does it allow any continuous coverage requirement.<sup>5</sup> The Secretary’s authority to “promulgate regulations with respect to enrollment periods” is limited to just that – defining the enrollment periods under which the issuer “must accept every employer and individual in the State that applies for such coverage.”<sup>6</sup>

### **Effective Dates for Terminations (§ 155.430)**

We support the proposal to simplify the process for enrollee termination of coverage by allowing termination to be effective on the day an enrollee requests, or on another prospective date selected by the enrollee. This change provides a more straightforward and commonsense approach for the consumer.

### **Essential Health Benefits**

The ACA’s Essential Health Benefits (EHB) provisions ensure that people living with chronic health conditions have access to the medically necessary care and treatment they require. Individuals living with chronic illnesses and disabilities need a minimum benefits package that includes the range of services and treatments needed to manage their conditions, including prescription drug benefits, substance use and mental health treatments, and preventive services. Additionally, because the ACA’s protections related to out-of-pocket maximums and annual and lifetime limits only apply to EHBs, weakening the EHB standard necessarily reduces the scope of these protections. We urge HHS to consider the following comments and ensure that the EHB package remains robust:

#### **State Selection of EHB-Benchmark Plan for Plan Years Beginning on or after January 1, 2019 (§ 156.111)**

We strongly oppose the proposal to alter the current EHB-benchmark plan selection process in the manner contemplated by this proposed rule. While the current EHB regulatory scheme provides clarity and transparency about EHB coverage standards and the reference plans used to select them. Removing this certainty, along with more limited oversight and regulation contemplated elsewhere in this proposed rule, will disrupt the coverage standards that consumers living with chronic conditions rely on.

Allowing states to choose a benchmark plan from another state, either wholesale or in part by choosing certain benefit categories, encourages states to choose less comprehensive benchmark plan options in an effort to control premium increases. While this may reduce overall premiums, out-of-pocket costs will rise for those that utilize their coverage more often, such as individuals living with chronic illnesses and disabilities, as certain services are excluded from the benchmark plan. Under no circumstances should HHS allow any new benchmark plan

---

<sup>4</sup> 42 U.S.C. § 300gg-1.

<sup>5</sup> *Id.*

<sup>6</sup> *Id.*

selections that result in lower actuarial value than currently exists in state benchmark plan options.

Similarly, we oppose allowing states to select a set of benefits that will become its EHB-benchmark plan. We believe that this process is not well defined and may not ensure adequate protection and coverage for consumers living with chronic health conditions. Further, the proposed definition of a “typical” employer plan could result in a benchmark comparison plan that is in fact an outlier in term of its plan design, allowing states to define a benchmark plan that is anything but typical. At a minimum, HHS should consider including a minimum actuarial value standard in the definition of a “typical” employer plan.

We note that the newly proposed benchmark plan options, in conjunction with other rules HHS proposes to apply to this process, create an incentive for states to only select new benchmark plans that are less comprehensive than current benchmarks. As outlined in the proposed rule, HHS proposes to apply the requirement at 45 C.F.R. § 155.170 to the newly proposed benchmark plan options. In particular, if a state selects a new benchmark that results in a requirement that insurers cover services not already mandated by the state prior to 2012, the state will be required to defray the additional cost of these benefits. Applying this requirement to the EHB benchmark selection process incentivizes a “race to the bottom” for states to select weaker benchmark plans. Further, this will restrict state flexibility and stifle the ability of states to regulate their health insurance Marketplaces to respond to the particularized needs of their states’ consumers. We urge HHS to create a process for states to address important market coverage gaps by allowing states to add new state-required benefits to the EHB without additional cost to the state.

We also note that the newly proposed benchmark plan selection process may unlawfully run afoul of nondelegation principles, particularly the third option outlined that allows states to define and select entirely new benchmark plan options. It is a well-settled point of administrative law that an agency such as HHS may not delegate its power to outside entities both private and sovereign.<sup>7</sup> As the ACA directs HHS to establish the EHB standard,<sup>8</sup> delegating this much authority over benchmark plan selections without well-defined constraints unlawfully cedes power to define EHBs to the states.

Finally, we support codification of existing ACA requirements to the EHB-benchmark standards, including requiring plans to provide an appropriate balance of coverage of the ten EHB categories, prohibiting benefit design that is unduly weighted towards any of the categories, and requiring that benefits are provided for diverse segments of the population, including people living with disabilities.

---

<sup>7</sup> See *United States Telecon Ass’n v. FCC*, 359 F.3d 552 (2004).

<sup>8</sup> 42 U.S.C. § 18022.

### **Provision of EHB (§ 156.115)**

We oppose the proposal to allow benefit substitution between EHB categories. We are concerned that this additional flexibility would result in an insufficient EHB standard. Allowing cross-category substitution would allow insurers to design plans that attract younger, healthier enrollees by providing fewer services that those living with chronic illnesses and disabilities rely on to stay healthy. HHS should carefully review any existing or new benefit substitutions to ensure that plans continue to provide an appropriate balance of benefits that attracts a well-balanced risk pool.

### **Notice and comment period for changes to EHB benchmarks**

We urge HHS to adopt strong and specific public engagement, notice, and comment requirements for when a state makes any change to its EHB benchmark plan. These requirements should include the following: a minimum 30-day public notice and comment period; a requirement that states post any proposed changes to the benchmark plan on a public website; and a requirement that states conduct at least one public hearing to solicit comments and engage stakeholders and consumers in the process. States should be required to submit documentation of their public notice and comment procedures to HHS.

### **Federal Prescription Drug Benefit Standard**

We do not believe that the prescription drug benefit standards should be overhauled at this time, and we urge HHS to avoid any significant changes to the way that the prescription drug benefit standard operates.

Instead, we believe that the best way to ensure access to lifesaving medications for people living with chronic illnesses and disabilities is for HHS to enforce existing coverage and non-discrimination protections. We urge HHS to focus on the following existing consumer protections:

#### **Treatment guidelines should inform prescription drug access**

Because people living with chronic conditions oftentimes depend on access to medications to stay healthy, any prescription drug requirement for private insurance must ensure affordable access to these populations that is in line with federal and national treatment guidelines. If HHS moves forward with a federal prescription drug benchmark, it should be measured against existing treatment guidelines to ensure meaningful coverage. For instance, if HHS retains the current “drug count” standard using a standard national reference plan, we urge HHS to incorporate national treatment guidelines to ensure that the benchmark plan covers the scope of medications that are clinically recommended for particular conditions.

#### **Formulary standards and nondiscrimination protections should be monitored and enforced**

Though the current ACA prescription drug standard does not ensure a strong enough minimum coverage standard, it does provide a necessary floor for coverage through inclusion of a drug count standard pegged to the benchmark plan. This standard is almost always higher than the inadequate one drug per class standard that would leave some people living with chronic health conditions without access to the treatment options they need to. We urge HHS to more closely

monitor compliance with the EHB drug count requirements, as past analyses have found that some issuers continue to design formularies that do not meet this standard. The drug counts should be regularly updated to reflect new therapeutic advances.

This current coverage floor must be coupled with strong non-discrimination oversight and enforcement to prevent issuers from using discriminatory plan designs to discourage enrollment of people living with chronic conditions. In addition to ensuring inclusion of lifesaving medications on plan formularies, it is equally important to ensure that utilization management techniques—including step therapy, adverse tiering, and excessive prior authorization requirements—are not used to bar access to clinically recommended treatment. These practices serve as barriers to effective treatment and can result in worse health outcomes for people living with chronic health conditions. We urge HHS to retain and to strongly enforce protections that prohibit discriminatory plan designs, including 45 CFR § 156.125; 45 CFR § 156.200(e); 45 CFR § 147.104(e); 45 CFR § 92.207.

Guidance has made clear that these protections prohibit plan designs that place all or most medications used to treat a particular condition on the highest cost or specialty tie. We urge HHS to increase its role in enforcing these protections to ensure access to medications for consumers living with chronic illnesses and disabilities from discrimination. The non-discrimination QHP federal review tool, which compares plan formularies to national treatment guidelines for a number of conditions should serve as a model for states enforcing and monitoring non-discrimination protections for vulnerable populations moving forward.

Prescription drug access and affordability continues to be one of the most important healthcare consumer challenges. We urge HHS to extensively evaluate the potential impact on people living with chronic illnesses and disabilities before making any changes to the prescription drug standard.

### **Network Adequacy, Essential Community Providers, and Other QHP Certification Standards**

While we understand the traditional role states have played in regulating insurance, we believe that there should be a strong federal-state partnership to ensure robust consumer protections. At a minimum, HHS should not abandon its role in setting and enforcing federal minimum standards with respect to QHP certification. We urge HHS to work to ensure that states have adequate capacity to undertake the increased regulatory responsibilities contemplated by this rule, particularly with respect to non-discrimination and access to care protections. In particular, we urge HHS to consider the following:

#### **State oversight of network adequacy and Essential Community Provider standards (§ 155.200)**

We urge HHS to continue requiring that SBE-FPs enforce FFE standards for network adequacy, including ECP standards. Strong minimum federal standards are necessary to ensure that states are not allowed to weaken these consumer protections. Similarly, we are concerned that completely relying on state reviews of network adequacy and ECP compliance for FFEs will

necessarily erode these protections. This proposed rule, along with the identical approach identified in the Market Stabilization rule, provide little details as to how states will be required to demonstrate that their review processes are sufficient. Robust networks are particularly important for people living with chronic illnesses and disabilities, for whom access to provider with expertise to treat their particular conditions is critical to ensure meaningful access to care.

Further, relying on issuer accreditation where states do not have authority and means to conduct network adequacy reviews is contrary to statute. The Secretary “shall, by regulation, establish criteria for the certification of health plans” to “ensure a sufficient choice of providers.”<sup>9</sup> These criteria must be subject to the full notice and comment requirements of the Administrative Procedure Act. The proposed deferral to private standards, however, does not meet the requirements for criteria established by regulation, as the public is unable to review and comment on these private standards.

While state regulators can and should play important role in enforcing network adequacy protections, HHS should ensure a strong federal minimum with specific quantitative standards to ensure access to providers.

#### **Essential Community Provider standard (§ 156.235)**

We urge HHS not to continue the reduced minimum ECP inclusion standard of 20 percent set forth by the Market Stabilization rule for the 2018 plan year. ECPs are particularly important for those living with chronic conditions that have established relationships with community providers, who are in the best position to ensure continuity of care. As we noted in our comments to the Market Stabilization rule, issuers have had no problems establishing network with the prior 30 percent standard. Indeed, as the proposed rule notes, only six percent of issuers were unable to meet this standard in 2017. As such, continuing with this reduced standard does not serve to reduce any significant burden on issuers, and may only disrupt continuity of care – actually increasing costs for issuers.

#### **State oversight of non-discrimination and other plan certification standards**

We urge HHS to reconsider its overall approach of increasing deference to states over critical plan certification areas, including non-discrimination reviews, accreditation standards, compliance reviews, and quality improvement. While states play a vital role in insurance regulation and oversight, we are concerned that HHS has not provided enough guidance and oversight to ensure that consumer protections are being adequately enforced. For example, HHS has not yet taken any action to resolve complaints of discrimination with respect to formulary offerings for enrollees living with HIV.<sup>10</sup> However, HHS expects states to take up enforcement of these standards, even where it has yet to adequately enforce them. We urge HHS to work closely

---

<sup>9</sup> 42 U.S.C. § 18031.

<sup>10</sup> *Schakowsky leads lawmakers in demanding answers for individuals living with HIV and AIDS*, (October 17, 2017) <https://schakowsky.house.gov/press-releases/schakowsky-leads-lawmakers-in-demanding-answers-for-individuals-living-with-hiv-and-aids/>.

with state regulators to fill these gaps, and at a minimum, develop best practices for states to monitor and enforce compliance with QHP standards.

**Meaningful Difference Standard for Qualified Health Plans in the Federally-Facilitated Exchanges (§ 156.298)**

We oppose the proposal to remove the meaningful difference standard outlined in 45 C.F.R. §156.298. Assessing plans for comprehensive coverage is already a complex and overwhelming process for consumers living with complex medical needs. The meaningful difference standard ensures that QHP offerings are easily distinguishable from one another and that consumers have the ability to readily differentiate and compare plans, leading to informed choices.<sup>11</sup> While we understand the need to ensure robust issuer participation on the Marketplaces, allowing insurers to offer plans that are opaque in their differences will confuse consumers and obscure the process of selecting an appropriate plan.

---

Thank you, again, for the opportunity to comment. We urge HHS to continue its commitment to implementing the ACA in ways that ensure that people living with chronic and complex conditions have access to quality, affordable health care coverage. Please contact Robert Greenwald with the Treatment Access Expansion Project ([rgreenwa@law.harvard.edu](mailto:rgreenwa@law.harvard.edu)), Amy Killelea with the National Alliance of State & Territorial AIDS Directors ([akillelea@nastad.org](mailto:akillelea@nastad.org)), or Jean McGuire at Northeastern University ([j.mcguire@neu.edu](mailto:j.mcguire@neu.edu)) if we can be of assistance.

Respectfully submitted by the co-chairs of the Chronic Illness and Disability Partnership

Robert Greenwald  
Treatment Access Expansion Project

Amy Killelea  
National Alliance of State & Territorial AIDS Directors

Jean McGuire  
Northeastern University

---

<sup>11</sup> Research suggests that consumers may prefer more limited arrays of choices. *See* Iyengar, S.; Lepper, M. *Journal of Personality and Social Psychology*, Vol. 79(6), Dec 2000, 995-1006.