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Submitted electronically via www.regulations.gov.

November 27, 2017

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

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

Dear Ms. Verma:

The Association of American Medical Colleges (the AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or Agency's) proposed rule entitled, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019," 82 *Fed. Reg.* 51052 (November 2, 2017).

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 149 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 167,000 full-time faculty members, 88,000 medical students, and 124,000 resident physicians. Together, these institutions and individuals are the American academic medicine community.

The AAMC appreciates CMS's efforts to improve the availability of affordable health insurance coverage in the individual and small group markets. We agree that consumers must have access to high-quality, high-value healthcare providers, and addressing ways to make health insurance more affordable is one way to achieve this goal. However, the AAMC is concerned that the proposed changes in the individual market – specifically, relaxing the regulations surrounding essential health benefits (EHBs), network adequacy and essential community providers for qualified health plans (QHPs) – may limit consumer choice; segment the insurance market, leading to de-stabilization and premium increases for sicker individuals; restrict patient access to providers; and leave providers who treat these patients either underpaid or not paid at all. The Association urges CMS to not finalize the rule as proposed.

Americans have benefited from the opportunity to purchase affordable health insurance coverage through the individual marketplace. Recent robust enrollment numbers for 2018 show that consumers are committed to securing coverage through the marketplaces, and indicate that the current marketplace rules are working, though revisions are needed to address premium increases.

The recent decision by the Administration to discontinue the cost-sharing reductions (CSRs) has increased the instability of the Exchanges, resulting in higher premiums for consumers and the exit of many health insurers from the marketplaces. This withdrawal from the individual insurance market has left many parts of the country with limited options for coverage; some counties will only have one insurer.[1] Health insurers that remain for 2018, on average, asked for a 34 percent increase in premiums for silver plans citing that the increases are a direct result of the elimination of CSRs.[2] Less insurer participation in the individual market will result in greater segmentation – sicker individuals staying in the market and younger, healthier individuals dropping out – and lead to even higher premiums for those left in the marketplace long term.

The AAMC understands the need for state flexibility, and that the reduction of regulatory burden is a worthwhile goal. However, the proposals to reduce or significantly eliminate Federal oversight to the states has the potential to jeopardize the ability of millions of Americans to obtain affordable, comprehensive health insurance coverage through the individual marketplace. The proposals, as outlined in the proposed rule, are likely to further destabilize the marketplace resulting in even less insurer participation and skyrocketing premiums, leaving many consumers with even fewer options for affordable health insurance coverage.

It is not patients alone who will feel the impact of this rule if it is finalized as proposed. Hospitals and physicians will find themselves treating more patients who are uninsured or underinsured. These patients may forego needed, routine care because of high cost-sharing responsibilities with the result that they will be sicker when they seek care, and thus will require an increased use of services and may wait until they need to come to an emergency room before seeing a provider. The AAMC urges CMS to work with stakeholders to improve the marketplace by finding ways to bolster insurer participation, stabilize premiums, and ensure robust health insurance coverage options for all Americans.

ESSENTIAL HEALTH BENEFITS

Currently, the Affordable Care Act requires non-grandfathered health plans that participate in the individual and small group markets, both on and off the Exchange, to cover ten essential health benefits: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease

[1] https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/
[2] http://avalere.com/expertise/managed-care/insights/silver-exchange-premiums-rise-34-on-average-in-2018

management; and (10) pediatric services, including oral and vision care.[3] While CMS has some discretion in determining what constitutes EHBs, the benefits must include coverage of items or services within the 10 basic categories. By setting this standard of benefits, consumers are assured of a uniform level of coverage among of health plans, and it prohibits insurers from cutting benefits just to reduce costs.

Beginning with the 2019 plan year, CMS is proposing to give states greater flexibility in defining their EHB benchmark plan, including the option to redefine the benchmark plan on an annual basis. While CMS believes these changes "would permit States to modify EHB to increase affordability of health insurance," (82 *Fed. Reg*. 51102) the AAMC is concerned, as explained in more detail below, that this change will allow some states to choose benchmark plans that offer sparse benefit packages. The result will be inadequate coverage to consumers, and segmenting the market as healthier consumers will choose plans with less robust coverage while those who are sick will choose plans with more robust coverage but significantly higher costs. In addition to insufficient coverage, premium subsidies tied to benchmark plans will restrict consumers' ability to purchase high-quality, high-value health plans because the financial assistance will not be sufficient, particularly for sicker individuals.

We agree that efforts to improve affordability are necessary. However, the AAMC is concerned that the proposals open the possibility that with affordability will come plans that do not meet the needs of consumers when, for example, they face a sudden major unexpected illness or injury. Reducing requirements for EHB benchmark plans might appear to improve affordability of plans through lower premiums in the short term; however, the benefits included in the plan may actually be so reduced that they are inadequate to provide for coverage of basic health needs.

Changes to EHB Requirements Should Not Reduce Health Care Coverage

In the proposed rule, CMS is proposing to expand the number of plan choices from which a state can select its benchmark plan. The plan a state chooses will determine the minimum amount of coverage plans offered on that state's Exchange will have to cover. In addition, the proposal adds flexibilities so that EHB compliant plans would be able to substitute benefits within and across categories as long as the substituted benefit was actuarially equivalent to the benefit being replaced. Prescription drug standard is not included.

Part of the ACA's goal to offer comprehensive health care coverage for all Americans included the requirement to provide coverage for items and services within the ten EHB categories. Current CMS policy requires states to select an EHB benchmark plan from among several actual plans in the state considered to be a typical employer plan. The requirement that coverage in these categories must be equal in scope to that provided under a "typical employer plan" so that consumers could be confident that the benefits of plans offered on the Exchange would be at least as generous as those offered by employers in their state.

Under the proposal, while a state's EHB benchmark plan would still need to be equal in scope to a typical employer plan, it would not necessarily have to be a typical employer plan in that state.

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[3] https://www.cms.gov/cciio/resources/data-resources/ehb.html

CMS is proposing to relax the requirement and to define a typical employer plan as "an employer plan within a product with substantial enrollment of at least 5,000 enrollees sold in the small group or large group market." (82 *Fed. Reg*. 51104) Lowering the enrollee threshold to 5,000 – which is lower than the current requirement in many states – brings into question whether some of the smaller plans that meet the standard are, in fact, "typical employer plans." If these plans are indeed not considered typical employer plans, then they will not provide robust EHB coverage which will put many consumers at a disadvantage when attempting to purchase insurance coverage that meets their needs.

The proposed changes to the EHB requirements signal what likely will be a reduction in the scope and level of coverage that plans will have to meet in order to be offered on state Exchanges. Under the proposal, States will be able to replace one or more EHB categories of benefits used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year. A state could, for example, select prescription drug coverage from another state's benchmark that provides for a different, and perhaps more narrow, formulary. The ability for a state to pick and choose the EHB to comprise their benchmark plan, including picking portions from another state's EHB or swapping benefits levels between categories, will result in lower coverage for certain items and services. Additionally, this reduction in required benefits will undermine patients' ability to purchase health care coverage that meets their needs. Knowing that there is a certain level of coverage that a plan is required to provide makes shopping for insurance coverage a little less overwhelming. Lastly, providing a wider variety of benefits has the potential to cause havoc with the risk pool. Healthier individuals will choose plans with less benefits, leaving consumers with greater health needs – *e.g.*, multiple chronic conditions – in plans with more substantial coverage and likely higher premiums.

Furthermore, changes to the definition of EHB has potential implications for state Medicaid expansion programs, which are required to use the state's EHB as the basis for the benefit package for expansion adults. The ACA expanded Medicaid coverage to individuals who were otherwise not eligible for coverage, namely single adults. For many, the expansion enabled individuals to secure coverage for chronic conditions that were previously untreated. Allowing states to change EHB packages will put at risk the coverage that these individuals have grown to depend on.

While the AAMC's comments focus on the impact on medical insurance, it is important to acknowledge the importance of dental health to overall health, particularly for the pediatric population. The proposed rule would allow states to benchmark an EHB in such a way that could remove pediatric dental coverage as an EHB. A state whose EHB benchmark only covers routine exams, cleanings, x-rays, and dental sealants but does not cover minor or major restorative treatments like fillings, crowns, and root canals that may be necessary to treat and manage tooth decay would provide substandard pediatric dental care coverage.

Transparency of Benefits and Cost-Sharing for Plans Offered on the Exchanges Is Necessary to Decrease Confusion as Consumers Compare Coverage Options

Coverage changes will likely exacerbate misperceptions that consumers already face when purchasing insurance coverage in the marketplace. Allowing states to annually re-define their benchmark plans will increase this confusion. While changes to EHB benchmark plans may appear to reduce premiums, patients' responsibility for deductibles and other cost sharing may actually rise. Only when patients attempt to receive care will they realize the full impact of these changes. For example, a patient diagnosed with cancer may realize that the insurance plan she selected does not provide adequate coverage for cancer treatments until she seeks medical treatment, leaving her with few options for these life-saving services. Or a family that finds out their newborn's neonatal intensive care unit (NICU) stay is not covered. In addition, patients may be shocked to discover that they do not have coverage, or that the coverage is inadequate, for needed medical treatment such as referral to a specialist for further treatment. Insufficient coverage for needed health care leads to gaps in seeking needed health care that results in poorer health for patients, the use of high-cost services, such as emergency department visits or hospitalizations that could have been prevented if adequate care were available.

CMS Must Ensure Consumers Eligible for Advanced Premium Tax Credits Can Continue to Attest to Their Income in Order to Qualify

The Affordable Care Act allows individuals to attest to estimates of projected income for the coming year in order to determine eligibility for advanced premium tax credits (APTCs) that help low-income individuals pay for health insurance. Currently, Exchanges are generally required to accept a consumer's attestation of an annual income estimate even if the projection is larger than the income data reported by the Internal Revenue Service and the Social Security Administration. CMS is proposing to change the verification process for increases in estimated household income for insurance affordability programs by requiring Exchanges to solicit additional documentation from consumers.[4] This proposal would require investigation of income discrepancies for individuals below 100% of federal poverty line (FPL), when an individual's discrepancy exceeds a reasonable threshold.

This proposal would create a significant new burden on individuals and for state-based marketplaces, creating delays in eligibility determinations or dissuading enrollment altogether. Many individuals with new jobs, newly self-employed, or starting a new business will have little documentation to demonstrate the likelihood of increased income before it is earned, making such a requirement a barrier to enrollment. In addition, this proposed change would be inconsistent with other federal regulations on reasonable compatibility of income verification for consumers applying for financial assistance for health coverage.

The ability for individuals to attest to their income for the coming year is particularly important for those with variable income, such as hourly workers, and those with unstable income, such as the seasonally or self-employed. Many of these individuals struggle to make ends meet; being

[4] 42 CFR 155.320

able to attest to future income projections allows them the peace of mind that they will have access to affordable health insurance coverage. If their good faith estimates prove inaccurate, there are already measures in place for their APTCs to be reconciled and recouped by the federal government. The CMS proposal to focus on individuals with expected increases in income will particularly affect those re-entering the workforce or working their way out of poverty and off of Medicaid. The AAMC urges CMS not to finalize this policy that will limit the ability of individuals with new or unstable income to attest to future year's annual income, and may result in more individuals who are uninsured.

QUALIFED HEALTH PLAN MINIMUM CERTIFICATION STANDARDS

CMS Must Continue to Provide Significant Oversight of QHPs in Order to Ensure Patients Continue to Have the Opportunity to Purchase Meaningful and Affordable Health Insurance

Currently, in order to be certified as a qualified health plans and be offered on the Exchanges, a plan must be meaningfully different from all other QHPs offered by the same insurer of that plan within a service area.[5] As CMS states in the rule, the meaningful difference standard was implemented to make it easier for consumers to understand differences between plans, and choose the right plan option for them." (82 *Fed. Reg*. 51111) CMS states that this standard is no longer necessary because with fewer insurers participating in the Exchanges there are fewer plans from which to choose. Furthermore, CMS believes that removing this requirement will provide insurers with more flexibility and thereby encouraging plan innovation. While the AAMC supports efforts to increase consumers' choice of high-value, affordable health insurance, we do not feel that removing oversight to guarantee meaningful insurance options is the way to achieve this outcome.

The AAMC believes there is a need for a higher degree of CMS input and oversight to ensure that QHPs offered through the Exchanges provide consistent and adequate coverage to enrollees nationwide. Giving states a larger role in the oversight of plans offered on the Exchanges will result in even greater variation of plans and increased confusion for consumers that purchase their coverage through the marketplace. While some plans may appear to offer ample coverage for needed medical services, consumers may not be aware of differences that may result in inadequate coverage for some services. Therefore, it is imperative that CMS continue its current level of oversight to ensure states provide accurate and transparent information to consumers.

NETWORK ADEQUACY

In the proposed rule, CMS is proposing to extend the QHP certification process it adopted in the final market stability rule (82 *Fed. Reg*. 18346) by eliminating the requirements for state-based exchanges on the federal platform (SBE-FP) to enforce requirements for network adequacy[6] and essential community providers (ECPs)[7] and allow SBE-FPs the flexibility to determine how

[5] 42 CFR 156.298
[6] 45 CFR 155.200(f)(2)(ii)
[7] 45 CFR 155.200(f)(2)(iii)

issuers offering QHPs through the SBE-FPs must comply. CMS believes that states are best positioned to determine the standards for the QHP certification process for their state. The AAMC is concerned that lowering these requirements for QHP certification may limit patient access to needed health care providers, particularly care at academic medical centers.

CMS Should Play a Key Role in Ensuring that All States Provide Network Adequacy

Beginning with the 2019 plan year, CMS would rely on state reviews for network adequacy of plans seeking certification as QHPs in states in which a federally facilitated exchange or an SBE-FP is operating and where the state has a sufficient network adequacy review process. CMS stated in prior rulemaking that it will require QHPs to maintain the "reasonable access standard"[8] for network adequacy, by relying on states with "the authority and means to assess issuer network adequacy" to determine whether or not a network meets the criteria for adequacy. For those states without the ability to conduct network adequacy reviews, CMS will rely "on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity."[9] These proposed changes would supersede the time and distance criteria currently required for QHP certification.[10]

In an effort to lower costs, insurers are eliminating currently-offered QHPs that have robust networks of doctors and hospitals and are replacing them with plans with narrow provider networks that limit patients to a select number of providers and decrease access to hospitals that provide specialized care. However, consumers enrolled in employer-sponsored insurance are more likely to continue to have access to plans with robust networks of doctors and hospitals. Limiting provider choice can be particularly detrimental for certain patient groups that already suffer from disproportionate levels of disease and death. In order to make inroads on improving the health and well-being of individuals, meaningful partnerships with local communities are paramount. That includes providing access to high-quality care for patients by ensuring that robust provider networks are offered by issuers in the individual and small group marketplaces. The AAMC is concerned that allowing states to determine the standards for QHP network adequacy without sufficient oversight by CMS has the potential to exclude teaching hospitals and faculty physicians from exchange plans, the very places where patients have available the most cutting-edge treatments and the highest level of expertise.

The AAMC believes that it is essential that QHP network standards do not undermine the goal of exchanges – to ensure there are sufficient providers and facilities included in a plan's network to ensure access for consumers – by allowing networks to be constructed in a manner that discourages access, and thus enrollment, of those with unique or high cost conditions, as a means to lower premiums. Furthermore, we strongly recommend that CMS continue to include the criteria for time and distance when determining whether an issuer is meeting the network adequacy requirements. Continuity of care is of particular importance in rural areas that struggle with physician shortages and is often compromised due to the lack of accessible providers.

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[8] 45 CFR 156.230(a)(2)
[9] 82 Fed. Reg. 32 (February 17, 2017)
[10] 2018 Letter to Issuers in the Federally-facilitated Marketplaces (December 16, 2016)

Compounding this problem is the distance patients must travel in order to seek care from specialists who are usually located at academic medical centers. Allowing insurers to exclude from their networks physicians and institutions solely on the basis that the valuable care they provide is perceived as too costly will only exacerbate the problems of access and lack of care continuity.

ESSENTIAL COMMUNITY PROVIDERS

CMS Should Not Reduce the Standard for Demonstrating a Sufficient Number and Geographic Distribution of Essential Community Providers

CMS is also proposing to allow states the ability to allow QHP issuers the ability to satisfy the regulatory standard for certification and recertification for the 2019 plan year and later if the issuer contracts with "at least 20 percent of available essential community providers (ECPs) in each plan's service area to participate in the plan's provider network"[11] as outlined in the final marker stability rule. As CMS has previously stated, this decrease from the current 30 percent ECP requirement necessary for certification is expected to "substantially lessen" the regulatory burden on issuers. Moreover, CMS states there will be cost savings as a result of loosening issuer requirements for network size. As the AAMC stated in response to this proposal in the proposed market stability rule, we urge CMS to keep the current 30 percent ECP requirement in order to ensure that patients have sufficient access to providers in their communities. While lessening regulatory burden is a laudable goal, it should not come at the expense of patients seeking care who will experience increased travel and wait times as a result of the decrease in available providers.

The AAMC remains concerned that this reduction in required ECPs will negatively impact vulnerable populations that rely on academic medical centers for their care. Major teaching hospitals and physician faculty practices serve a disproportionately large volume of underserved, low-income individuals, provide access to essential health services for disadvantaged groups, and are often the last resort for treatment for many. Academic medical centers serve as the backbone of many communities' health care infrastructure. However, in past years, QHP plan issuers have been allowed to exclude these institutions from their networks putting pressure on patients to sever ties with providers with whom they have established doctor-patient relationships or incur financially burdensome cost sharing in order to maintain continuity of care.

NAVIGATOR PROGRAM STANDARDS

CMS Should Not Reduce Requirements for Navigators

The ACA required that each Exchange establish a Navigator program under which it awards grants to entities to raise public awareness, educate consumers on the availability of QHPs and to facilitate enrollment in QHPs. Under existing rules, each Exchange is required to have at least two Navigator grantees, with one being a community and consumer-focused nonprofit group.[12]

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[11] 82 Fed. Reg. 10990-10991
[12] 42 CFR 155.210(c)(2)

Additionally, each Navigator is required to maintain a physical presence in the Exchange service area, so that face-to-face assistance can be provided to applicants and enrollees.[13]

CMS proposes to remove the requirements that each Exchange have at least two Navigator entities and that one of these entities be a community and consumer-focused nonprofit group as well as the requirement for the Navigator to have a physical presence in the Exchange service area. These proposed changes are on top of dramatic funding cuts Navigators experienced in advance of the 2018 open enrollment period.

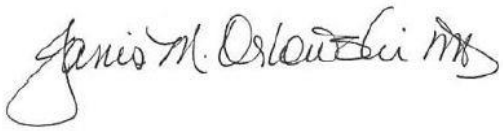
The Navigators have successfully assisted many consumers in signing up for insurance through their state's health insurance Exchange, such as self-employed, small businesses or individuals without access to employer-sponsored insurance. They also help individuals eligible for Medicaid to enroll. Many of the Navigator grantees live and work in the communities they serve. They are trusted to do what's right to assist their neighbors.

The AAMC urges CMS not to further weaken Navigators that provide valuable assistance to consumers that enroll in health plans offered through the Exchanges, particularly at a time when choosing a plan in an Exchange may become even trickier. As mentioned earlier, CMS must improve transparency so consumers are able to sift through insurance options in their state in order to enroll in the plan that best meets their needs. To that end, Navigators are needed now more than ever to provide guidance to consumers.

Conclusion

Thank you for the opportunity to comment on the proposed changes to Benefit and Payment Parameters for 2019. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at 202.909.2084 or mmullaney@aamc.org.

Sincerely,



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cc: Ivy Baer, J.D., M.P.H, AAMC
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[13] 42 CFR 155.210(e)(7)