

National
Family Planning
& Reproductive Health Association

November 27, 2017

VIA ELECTRONIC SUBMISSION

Acting Secretary Eric Hargan
CMS Administrator Seema Verma
Center for Medicare & Medicaid Services
US 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; Benefit and Payment Parameters for 2019
(CMS-9930-P)**

Dear Acting Secretary Hargan and Administrator Verma:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to respond to the Patient Protection and Affordable Care Act benefit and payment parameters for 2019 proposed rule issued by the US Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) related to a broad range of Affordable Care Act (ACA) provisions, including network adequacy, essential health benefits (EHBs), and essential community providers (ECPs).

NFPRHA is a national membership organization representing providers and administrators committed to helping people get the family planning education and care they need to make the best choices for themselves and their loved ones. NFPRHA's members operate or fund a network of more than 3,500 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 50 states, the District of Columbia, as well as US territories. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers, and other private nonprofit organizations.

ESSENTIAL COMMUNITY PROVIDERS

The ACA has ensured that millions of women have access to coverage that provides a broad range of preventive health benefits, including contraception, cancer screenings, and well-woman visits, at no additional cost to the patient. Providing insurance coverage to millions of uninsured individuals is a significant advance for public health and achieving health equity for women; however, access to coverage does not equal access to care. The ECP provision was included in the ACA to ensure that patients, particularly newly insured low-income and medically underserved patients, may continue to receive care from the safety-net providers they relied on prior to obtaining coverage.

NFPRHA commends HHS and CMS for their continued commitment to ensuring access to health care for low-income and medically underserved individuals through the ECP provision. However, NFPRHA has concerns about the ongoing reduction in the ECP participation threshold restricting access to important health services. As CMS continues its statutory obligation to implement the ECP provision, NFPRHA encourages CMS to strengthen protections for the most vulnerable patient populations, rather than reversing the progress that has already been made.

NFPRHA strongly urges CMS to raise the ECP participation threshold back to a minimum of 30 percent.

As safety-net family planning providers serving predominantly low-income and medically underserved patients, NFPRHA's members are uniquely situated to understand the barriers to coverage and access that patient population faces. With that in mind, NFPRHA is concerned that maintaining the participation threshold at 20% of ECPs in an issuer's service area could have a significantly negative impact on patient access to needed care. In fact, NFPRHA has repeatedly urged HHS to increase the 30% threshold, arguing that narrow provider networks continue to be a barrier for low-income and medically underserved patients.

Many newly insured individuals covered by Marketplace plans were previously uninsured and accessed health care through safety net programs. Maintaining the ability of these patients to continue to seek care from their trusted family planning providers and other ECPs is important. Through Medicaid expansion and tax credits, the ACA has increased the number of low-income Americans with health insurance coverage. Many of these patients have relied, and continue to rely, on safety-net family planning health centers for a wide range of preventive health services, such as breast and cervical cancer screening and screening for sexually transmitted diseases (STDs) and HIV, as well as contraceptive counseling, services and supplies. It is imperative that family planning ECPs continue to be included in QHP networks to ensure that their patients can continue to be able to access these services.

NETWORK ADEQUACY

Demonstrating Congress's focus on ensuring access to health care providers, the ACA requires the Secretary to establish network adequacy requirements for insurers seeking QHP certification under §156.230.¹ In its proposal, the Department indicates its intention to continue deferring to states to certify that QHPs comply with the federal network adequacy standard. Consumer experiences in accessing providers vary across states, with some state standards assessing travel time and distance, others provider-to-enrollee ratios, others appointment wait time and extended hours of operation.² Further, states' processes to regulate and assess plan's provider networks also vary. This variety highlights the need for a federal minimum floor to which insurers must adhere and helps ensure that consumers can still participate in a competitive and quality health insurance market regardless of where they live. It is also not sufficient under the statute to rely on accrediting bodies to assess provider networks. Relying on states to certify compliance with the federal network adequacy standard is a piecemeal approach to assessing provider networks and in particular, this approach will continue to create a health care system that does not reflect the unique needs of women.

NFPRHA urges HHS to establish federal network adequacy standards and ensure that qualified health plans provide reasonable access to providers

HHS must establish a strong network adequacy standard for Marketplace issuers in all states. Network adequacy standards must be strong and ensure that networks are sufficient to meet women's health needs and provide timely access to providers that specialize in women's primary health care, including family planning and sexual health care, and women's preventive services. To ensure that enrollees across the country have timely access to appropriate, geographically accessible providers who can deliver the health services covered under their plans, the Department should not only continue its current practice of using time and distance standards to assess provider networks, but also adopt stronger network adequacy standards in regulation to uphold and meaningfully implement the statutory requirements for network adequacy under the ACA.

Recognizing the existing challenges for women's health access, it is critical that federal network adequacy standards also include metrics that ensure access to a broad range of women's health services, including family planning and sexual health care. Improving upon the existing federal network adequacy standards will help ensure that plan networks meet the needs of consumers and provide timely access to covered services. Moreover, the Department should establish a broad set of metrics and criteria that includes, but is not limited to: time and distance standards; provider-to-enrollee ratio minimums; availability of providers accepting new patients; assessment of the range of provider types in a plan's network; and appointment

¹ 42 U.S.C. § 18031(c)(1)(B).

² J. Giovanelli, Commonwealth Fund, Implementing the Affordable Care Act State Regulation of Marketplace Plan Provider Networks (May 2015), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/may/1814_giovanelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.

wait time standards.

ESSENTIAL HEALTH BENEFITS

The essential health benefit (EHB) requirement has helped ensure people have access to *basic* health care services and has closed health care coverage gaps that for decades had left individuals underinsured. Before the ACA, consumers often did not have health coverage for services that are now covered as EHBs. For example, prior to the ACA, one in five people enrolled in the individual market lacked coverage of prescription drugs and mental health coverage was often excluded from health plans.³ Also, 75% of non-group market plans did not cover maternity care (delivery/inpatient care), and 45% did not cover inpatient/outpatient substance use disorder services.⁴ These services can be a small percentage of the relative benefit costs in commercial market plans, yet scaling back on their coverage would significantly raise out-of-pocket costs for individuals who need them.⁵

NFPRHA urges HHS to maintain a robust EHB standard which ensures access to needed health care services.

HHS' proposed changes to the EHB benchmark options, including the proposed definition of a "typical employer plan," would jeopardize adequate coverage of the ten EHB categories. HHS' proposal strongly emphasizes reducing coverage and lowering premiums, which will result in inadequate coverage of benefits and higher out-of-pocket costs for consumers. We are concerned that HHS' proposed EHB benchmark options may lead to the selection of rare, outlier benchmarks, with extremely limited coverage of critical services.

In the preamble to the proposed rule, HHS anticipates that, given the new benchmark options, states are more likely to select EHB benchmark plans that will reduce premiums.⁶ As such, HHS recognizes that consumers with specific health care needs may be offered less comprehensive plans that no longer cover certain services.⁷ Under HHS' proposal, people who rely on services that are no longer considered EHBs will have to pay out-of-pocket for them or forgo the care they need. In addition, the out-of-pocket maximum and annual and lifetime limit consumer protections will no longer apply to services that are not considered EHBs since these protections only apply to EHBs. This will increase health care costs for many, including people

³ Dania Palanker et al., *Eliminating Health Benefits Will Shift Financial Risk Back to Consumers*, The Commonwealth Fund, Mar. 24, 2017, <http://www.commonwealthfund.org/publications/blog/2017/mar/eliminating-essential-health-benefits-financial-risk-consumers>.

⁴ Gary Claxton et al., *Would States Eliminate Key Benefits if AHCA Waivers are Enacted?*, Kaiser Family Foundation, June 14, 2017, <https://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/>.

⁵ Rebekah Bayram & Barbara Dewey, *Are Essential Health Benefits Here to Stay?*, Milliman, March 2017, <http://us.milliman.com/uploadedFiles/insight/2017/essential-health-benefits.pdf>.

⁶ 82 Fed. Reg. 51131.

⁷ *Id.*

with pre-existing conditions.⁸ It will also drive up medical debt and health-related bankruptcies, which have ameliorated since the ACA was enacted.⁹

An increase in out-of-pocket costs is not what consumers want. Two-thirds of consumers—67%—believe that the top health care priority should be to lower, not increase, their out-of-pocket costs.¹⁰ Consumers value comprehensive benefits and the ACA’s consumer protections. At least two-thirds of marketplace enrollees—65% or more—reported satisfaction with their qualified health plan in 2014 through 2016 in three separate national surveys.¹¹ To improve their coverage, most consumers want policymakers to lower the cost of prescription drugs, to ensure that benefits are comprehensive, and to improve network adequacy.¹² That is not what this proposed rule does.

A robust EHB standard is essential to individuals receiving effective care. In the preamble of the proposed rule, HHS recognizes that offering less coverage may result in “spillover” effects, including increased use of emergency services and other services provided by safety-net and government-funded providers.¹³ This not only affects the individual patient but also impacts our productivity as a nation, and ultimately increases the cost of health care.

The proposed EHB benchmark options put consumers in the individual and small group market at risk of increased health care costs, and may also impact an estimated 27 million workers and their dependents who receive coverage through large employers.¹⁴ Annual and lifetime limits on coverage apply to large employer plans as well, and these plans can choose

⁸ Sarah Lueck, *Administration’s Proposed Changes to Essential Health Benefits Seriously Threaten Comprehensive Coverage*, Center on Budget and Policy Priorities, November 7, 2017, <https://www.cbpp.org/research/health/administrations-proposed-changes-to-essential-health-benefits-seriously-threaten>.

⁹ Allen St. John, *How the Affordable Care Act Drove Down Personal Bankruptcy*, Consumer Reports, May 2, 2017, <https://www.consumerreports.org/personal-bankruptcy/how-the-aca-drove-down-personal-bankruptcy/>.

¹⁰ Ashley Kirzinger et al., *Kaiser Health Tracking Poll: Health Care Priorities for 2017*, Kaiser Family Foundation, Jan. 6, 2017, <https://tinyurl.com/ychedlcaz>.

¹¹ U.S. Government Accountability Office, *Most Enrollees Reported Satisfaction with their Health Plans, Although Some Concerns Exist*, GAO-16-761, Sept. 2016, <https://www.gao.gov/assets/680/679673.pdf>.

¹² Drew Altman, “The Health Care Plan Trump Voters Really Want,” *New York Times* (Jan. 5, 2017), <https://www.nytimes.com/2017/01/05/opinion/the-health-care-plan-trump-voters-really-want.html>; Ashley Kirzinger et al., *supra*, note 8; Jennifer Tolbert & Larisa Antonisse, *Listening to Trump Voters with ACA Coverage: What They Want in a Health Care Plan*, Kaiser Family Foundation, Feb. 2017, <http://files.kff.org/attachment/Issue-Brief-Listening-to-Trump-Voters-with-ACA-Coverage-What-They-Want-in-a-Health-Care-Plan>.

¹³ 82 Fed. Reg. 51131.

¹⁴ Topher Spiro & Emily Gee, *The Emerging Senate Repeal Bill Eviscerates Protections for Millions in Employer Plans Nationwide*, Center for American Progress, June 15, 2017, <https://www.americanprogress.org/issues/healthcare/news/2017/06/15/434042/emerging-senate-repeal-bill-eviscerates-protections-millions-employer-plans-nationwide/>; See also Matthew Fiedler, *Like the AHCA, the Senate’s health care bill could weaken ACA protections against catastrophic costs*, Brookings Institute, June 23, 2017, <https://www.brookings.edu/blog/up-front/2017/06/23/like-the-ahca-the-senates-health-care-bill-could-weaken-aca-protections-against-catastrophic-costs/>.

any state’s definition of EHBs for purposes of adhering to this prohibition. But these limits only apply to benefits that are considered EHBs. Thus if any state drops its EHB coverage significantly, anyone getting employer–sponsored insurance across the country may once again face annual or lifetime limits as well as higher cost–sharing for benefits that are no longer considered EHBs.

HHS’ proposed change to the substitution of benefits policy will also negatively impact coverage of critical services. HHS admits that allowing substitution of benefits within the same EHB category *and* between EHB categories, as it proposes to do, will increase the burden on consumers who will have to spend more time and effort comparing benefits offered by different plans in order to “determine what, if any benefits have been substituted, and what plan would best suit their health care and financial needs.”¹⁵ In addition, HHS notes that by allowing substitution between EHB categories, “states may encounter difficulties in ensuring that all categories are filled in such a way that amounts to EHBs.”¹⁶ This proposed policy change, like the change in benchmark options, serves to negate coverage of the ten EHB categories and will lead to extremely different benefits packages, confused consumers, increased administrative costs to states, and inadequate coverage of critical services. This undermines some of the basic guarantees of the ACA, such as a simple and navigable insurance market for consumers.

Statutory Requirements

There is a clear directive in the ACA *requiring the Secretary of HHS* to define the EHBs, and as a legal matter, HHS has no authority to delegate defining the EHBs to states or issuers. For example, the ACA expressly requires the Secretary of HHS (Secretary) to develop standards, factoring a number of considerations (with emphasis added):

- In §1302(a): “...with respect to any health plan, coverage that ... provides for the essential health benefits defined by the Secretary...”
- In §1302(b)(1): “...the Secretary shall define the essential health benefits...”
- In §1302(b)(2)(A): “The Secretary shall ensure that the scope of the essential health benefits ... is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey ... and provide a report on such survey to the Secretary.”
- In §1302(b)(2)(B): “In defining the essential health benefits ... the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services...”
- In §1302(b)(3): “In defining the essential health benefits ... the Secretary shall provide notice and an opportunity for public comment.”

¹⁵ 82 Fed. Reg. 51131.

¹⁶ *Id.*

- In §1302(b)(4): “In defining the essential health benefits ... the Secretary shall--”
 - “ensure that such essential health benefits reflect an appropriate balance among categories...so that benefits are not unduly weighted toward any category”
 - “not make coverage decisions...or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life”
 - “take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups”
 - “periodically review the essential health benefits ... and provide a report to Congress and the public....”
 - “periodically update the essential health benefits ... to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted....”

Nowhere does the ACA authorize the Secretary to delegate its responsibilities. As mentioned above, per the ACA, the Secretary of HHS must also periodically review the EHBs and provide a publicly available report to Congress. That review must contain an assessment: (1) of whether enrollees are experiencing barriers to needed services, (2) of whether services should be modified or updated to account for changes in medical evidence or scientific advancement, (3) addressing gaps in access or changes in evidence base, and (4) of whether existing benefits need to be expanded or reduced and the impact on cost.¹⁷ In this proposed rule, HHS is proposing the most drastic changes to the EHB standard to date without having completed the required review of the current standard.

NFPRHA appreciates the opportunity to provide comment on the benefit and payment parameters for 2019 proposed rule. If you require additional information about the issues raised in this letter, please contact Mindy McGrath, NFPRHA Director, Advocacy & Communications, at 202-552-0144 or at mmcgrath@nfprha.org.

Sincerely,



Clare Coleman
President & CEO

¹⁷ 42 U.S.C. § 18022(b)(4)(G).