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**Attn: CMS-9930-P  
NPRM Notice of Benefit and Payment Parameters for 2019**

Thank you for the opportunity to comment on HHS' proposed HHS Notice of Benefit and Payment Parameters for 2019 proposed rule. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals, by advocating, educating and litigating at the federal and state level.

We have provided our specific comments below.

**§ 155.20 – Standardized Options**

We do not support the proposed changes to eliminate standardized options. Having standardized options assists consumers in making informed choices.

When plans share a common benefits structure, including tiering and cost sharing, consumers can make apples-to-apples comparisons of plans and benefits. We also believe there is great value for consumers in simplified options, particularly when those options match high-value designs.

## § 155.106 and § 155.200 – Flexibility for State-Based Exchanges and State-Based Exchanges on the Federal Platform

We support the concepts of providing additional information and flexibility for state-based exchanges on the federal platform. However, we are concerned that providing this flexibility may be at the expense of making needed technological improvements to the overall system. As HHS noted in the preamble and in prior rulemaking, operational limitations currently preclude HHS from offering a “menu” of Federal services from which SBE-FP can select (82 Fed. Reg. 51081). We believe a number of improvements to healthcare.gov as a whole should be prioritized when resources and time are limited to work on the entire system. For example, we have previously suggested changes to the Eligibility Determination Notice (EDN) that have been put off due to technology limitations. We have also suggested integrating appeals notices and information into the healthcare.gov infrastructure so that consumers, as well as call center representatives, can access appeals notices and decisions in their healthcare.gov accounts. HHS should also prioritize systems upgrades to improve the flow of the application, to merge applications 1.0 and 2.0 so that all consumers can have a streamlined experience, and to change language of various questions to ensure all eligible consumers provide the correct information (e.g., clearly informing domestic violence survivors that they can file taxes without their married partner). We have provided numerous suggestions over the past years and urge HHS to take up those changes prior to using limited resources and time to address state-specific issues.

### Essential Health Benefits Package

#### *General Comments*

We are opposed to HHS' proposed changes to the Essential Health Benefits (EHBs) standard which would lower the threshold of covered services and leave many consumers without access to the health care they need. The 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.<sup>1</sup>

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<sup>1</sup> 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>.

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.<sup>2</sup> 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.<sup>3</sup>

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.<sup>4</sup> As such, HHS recognizes that consumers with specific health care needs may be offered less comprehensive plans that no longer cover certain services.<sup>5</sup> 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 with pre-existing conditions.<sup>6</sup> It will also drive up medical debt and health-related bankruptcies, which have ameliorated since the ACA was enacted.<sup>7</sup>

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.<sup>8</sup> Consumers value comprehensive benefits and the ACA's consumer protections. At least two-thirds of marketplace enrollees—65% or more—reported

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<sup>2</sup> 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/>.

<sup>3</sup> 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>.

<sup>4</sup> 82 Fed. Reg. 51131.

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

<sup>6</sup> 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>.

<sup>7</sup> 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/>.

<sup>8</sup> Ashley Kirzinger et al., *Kaiser Health Tracking Poll: Health Care Priorities for 2017*, Kaiser Family Foundation, Jan. 6, 2017, <https://tinyurl.com/ychdlcaz>.

satisfaction with their qualified health plan in 2014 through 2016 in three separate national surveys.<sup>9</sup> 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.<sup>10</sup> 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.<sup>11</sup> 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.<sup>12</sup> Annual and lifetime limits on coverage apply to large employer plans as well, and these plans can choose **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,

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<sup>9</sup> 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>.

<sup>10</sup> 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>.

<sup>11</sup> 82 Fed. Reg. 51131.

<sup>12</sup> 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/>.

and what plan would best suit their health care and financial needs.”<sup>13</sup> 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.”<sup>14</sup> 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.”
- 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....”

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<sup>13</sup> 82 Fed. Reg. 51131.

<sup>14</sup> *Id.*

- “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.<sup>15</sup> 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.

### ***Specific Comments***

#### **§ 155.170 – Additional Required Benefits**

HHS reiterates that the current state benefit mandate policy will continue to apply. Therefore, state benefit mandates enacted after December 31, 2011, other than for purposes of compliance with federal requirements, will continue to be considered in addition to EHB and states will be required to defray the cost of the mandated benefit. HHS proposes to apply this mandate policy even if the mandated benefit is embedded in the state’s newly selected EHB benchmark plan.

As we noted in our comments on the 2017 Notice of Benefits and Payment Parameters, HHS’ current policy on state benefit mandates has effectively ended implementation of new state mandates, particularly as they apply to Marketplace health plans, because of the potential costs to the state.<sup>16</sup> We urged HHS to create a process for states to address important market coverage gaps by adding new benefits without additional cost to the state. This proposed rule does not take up this recommendation and, unfortunately, seems to go in the opposite direction, limiting opportunities to improve and expand benefits—a move that actually *reduces* state flexibility.

Most of the 2017 EHB benchmark plans, which would serve as the benchmarks for two of the three new options provided in this proposed rule, and for the new default benchmark, do not cover certain services, including acupuncture, bariatric surgery, hearing aids, routine foot care, weight loss programs, and infertility treatment. By continuing to use these benchmarks while at the same time maintaining the restrictive mandated benefit policy,

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<sup>15</sup> 42 U.S.C. § 18022(b)(4)(G).

<sup>16</sup> Letter from Elizabeth G. Taylor, Nat’l Health Law Prog., to Centers for Medicare & Medicaid Services (Dec. 21, 2015) (comments on HHS Notice of Benefit and Payment Parameters for 2017), available at <http://www.healthlaw.org/issues/health-care-reform/2017-Parameters#.WgniTohOkdU>.



there is no way for the state to cover those services without having to defray the cost. It is important to allow states the flexibility to improve benefit coverage to help meet the health goals of the state.

In addition, HHS' policy that states will not have to defray the cost for state mandates enacted for purposes of compliance with federal requirements continues to apply, but there is no clarity as to when this applies. Additional guidance should be provided to states so that they understand which types of benefit mandates states may enact to comply with federal requirements and avoid having to defray the costs.

Another consequence of HHS' state mandate policy is that states may refuse to apply state mandates to individual and small group market plans due to costs. For example, Alabama recently enacted a state coverage mandate requiring coverage of diagnosis, screening, and treatment of Autism Spectrum Disorder (ASD) for children and young adults ages 18 and under, but this mandate does not apply to plans in the individual and small group markets.<sup>17</sup> In addition, we are concerned that this policy in conjunction with the proposed options for selecting EHB benchmark plans will encourage states to select a less comprehensive EHB benchmark plan, resulting in less coverage for 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. A public process should be created to give states the flexibility to add needed mandates so that they can improve coverage and meet the health needs of those residing in the state, including for communities who experience health disparities.

### **§ 156.100 – § 156.111 State Selection of Benchmark Plans**

HHS proposes to replace the current § 156.100 with a new § 156.111 for plan years beginning on or after January 1, 2019. Below are our comments on the proposed changes, noting our ongoing concerns with the legality of allowing states to set the EHBs.

#### *New Default Benchmark*

HHS proposes that if a state does not make an EHB benchmark selection by the annual selection date for the applicable plan year, then the state's EHB benchmark plan for the prior year will continue to apply. While we appreciate the opportunity for states to keep their current EHB benchmark plan if they so desire, this does not allow states to select the updated version of their current benchmark. The 2017 benchmark plans are based on 2014 plans and many of them are not in compliance with existing EHB requirements (e.g.,

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<sup>17</sup> H.B. 284, 2017 Reg. Sess. (Ala. 2017), <http://alisondb.legislature.state.al.us/ALISON/SearchableInstruments/2017rs/PrintFiles/HB284-enr.pdf>.

preventive services) or with EHB standards that went into effect in 2016 and 2017 (e.g., prescription drug requirements).

### *New EHB Benchmark Options*

We strongly oppose HHS' proposed new EHB benchmark options for plan year 2019 and beyond. We are concerned that the changes that HHS proposes to the EHB benchmark process will reduce the comprehensiveness of coverage for consumers by allowing states to drop or limit the benefits that are currently covered in their state, give insurers more latitude to deviate from a state's EHB standard, and weaken consumer protections against catastrophic out-of-pocket costs in large employer plans. These changes would disproportionately impact individuals with disabilities and people with pre-existing medical conditions who could face reduced access to the services they need and higher out-of-pocket costs.

#### *Benchmark Option #1: Select another state's 2017 EHB benchmark*

HHS proposes to allow states to select the EHB benchmark plan that another state used for the 2017 plan year. For a number of reasons, we oppose this proposal. For example, HHS indicates that this would increase the number of selection options without requiring extensive analysis since all of the benchmarks are posted on CCIO's website. However, the documents posted on the CCIO website are not all up-to-date in terms of ACA requirements. Also, plan documents posted on the CCIO website often refer to additional documents for coverage details, such as a benefits schedule, which is not included. To further complicate matters, generally the evidence of coverage or certificate of coverage documents are confusing or incomplete, and many times the documents include multiple amendments which make it difficult to determine covered benefits. In addition, the benefits and limits charts currently provided for each state along with plan documents offer varying level of detail from state to state, with most states simply indicating whether a benefit is covered.

There are also significant process concerns. Most states completed an analysis of the ten EHB benchmark plan options and made a transparent decision. For example, California's legislature selected its benchmark plan after a public comment period and released its plan analysis publicly. However, some states fell short of this level of transparency.<sup>18</sup> In Mississippi, the State Department of Insurance decided on a benchmark together with

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<sup>18</sup> Sabrina Corlette, Kevin W. Lucia, and Max Levin, *Implementing the Affordable Care Act: Choosing an Essential Health Benefits Benchmark Plan*, The Commonwealth Fund, 6-7, March 2013.

[http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Mar/1677\\_Corlette\\_implementing\\_ACA\\_choosing\\_essential\\_hlt\\_benefits\\_reform\\_brief.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Mar/1677_Corlette_implementing_ACA_choosing_essential_hlt_benefits_reform_brief.pdf)



industry stakeholders. This process did not include a publicly released plan analysis or formal comment period. By allowing states to use the benchmarks of other states, HHS' proposal separates the chosen benchmark plan from the state-specific process that created it.

*Benchmark Option #2: Replace one or more EHB categories with coverage from another state's 2017 EHB benchmark*

HHS proposes to allow states to replace one or more EHB category of benefits in its EHB benchmark plan used for the 2017 plan year with the same category of benefits from another state's EHB benchmark plan used for the 2017 plan year. We oppose this proposal, for the reasons stated above. Moreover, it would be very difficult for states to know what other states cover in each of the EHB categories since the documents that are posted online are not split into EHB categories and the evidence of coverage documents for the benchmark plans are not labeled in that way either. Also, the benefits that fall under the EHB categories are not mutually exclusive, therefore it would be very difficult for a state to identify the services to replace in one or more of the EHB categories.

*Benchmark Option #3: Select a set of benefits that become the state's EHB benchmark plan*

HHS proposes to allow states to select a set of benefits that would become the state's EHB benchmark plan using a different process from that described above, provided that the selection does not exceed the generosity of the most generous of comparison plans. Per our general comments above, we oppose this proposal and are concerned that it will lead to a race to the bottom by allowing states to provide minimal coverage of EHB categories in 2019 and beyond.

In addition, in the Notice of Benefit and Payment Parameters for 2016 final rule, HHS noted that states retain the ability to determine whether the EHB base-benchmark plan covers an EHB category or whether supplementing is warranted.<sup>19</sup> But as we pointed out in our comments to the Proposed 2017 EHB Benchmark Plans, for the most part, it appears states are only supplementing when an EHB base-benchmark plan does not cover *any* items or services in one of the ten EHB statutory categories. Therefore a plan with minimal or inadequate coverage in one of the 10 EHB categories does not always get supplemented. This will most likely continue to happen with the proposed benchmarks leading to inadequate coverage of critical services.

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<sup>19</sup> HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750, 10,813 (Feb. 27, 2015) (to be codified at 45 C.F.R. pts 144, 147, 153, 154, 155, 156, and 158), available at <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>.

We appreciate that HHS proposes to add into the regulation the ACA requirements that EHBs be defined in a way that ensures appropriate balance among categories, that benefits are not unduly weighted toward any category, and that diverse segments of the population (such as women, children, and people with disabilities) must be taken into account. That section of the ACA also says that benefits cannot be designed in ways that discriminate against individuals because of their age, disability, or expected length of life.<sup>20</sup> This language prohibiting discriminatory benefit design should be added to the regulatory text as well.

### *Public Comment*

If HHS allows states to select new EHB benchmarks for the 2019 plan year and beyond, states should be required to provide reasonable opportunity for notice and public comment. Notice and comment should include public hearings, a public comment period, and the publication of plan documents and analysis in usable and understandable formats, along with data (such as actuarial certifications and reports) that must be submitted to HHS.

### *Longer-Term Approach*

For plan years in the future, HHS indicates that it is considering establishing a federal default definition of EHB. As stated above, the Secretary must establish EHBs consistent with the instruction set forth in the ACA.

## **§ 156.111(b)(2)(i) – Definition of Typical Employer**

The ACA requires that coverage of EHBs in the individual and small group market be equal in scope to the benefits provided under a typical employer plan.<sup>21</sup> The law gives the Secretary of HHS the authority to determine the scope of a typical employer plan but requires that the Secretary's determination be informed by a survey of employer-sponsored coverage conducted by the Department of Labor (DOL).<sup>22</sup> The typical employer requirement guarantees minimum coverage of EHBs.

The proposed rule would define a typical employer plan as “an employer plan within a product [...] with substantial enrollment in the product of at least 5,000 enrollees sold in the small group or large group market, in one or more states, or a self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more states.”<sup>23</sup> We object to this definition of typical employer plan for two reasons. First, the proposed definition fails to take into account the DOL's report from 2011, which summarizes some of the benefits that are typically covered by employer plans, and ignores the concept of

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<sup>20</sup> 42 U.S.C. § 18022(b)(4)(B).

<sup>21</sup> 42 U.S.C. § 18022(b)(2)(A).

<sup>22</sup> *Id.*

<sup>23</sup> 82 Fed. Reg. 51104.

typicality of benefits as adopted in the ACA. Second, adopting the proposed definition of a “typical employer plan” would lower the threshold for minimum coverage of EHBs, opening the door for insurers to offer plans with skimpier benefits and weakening the protections that the ACA affords to individuals with disabilities and complex medical needs.

As required by the ACA, between 2010 and 2011, the DOL conducted a survey of employer-sponsored health coverage to inform the Secretary of HHS’ determination of benefits typically covered by employers. The survey captured data from about 36,000 employers, including both private employers and state and local governments, and produced comprehensive information on the provisions of employment-based health care benefits from a representative sample of about 3,900 employers. The survey’s findings were summarized in a report to HHS published in 2011.<sup>24</sup> While the previous administration did not explicitly define a typical employer plan in determining the scope of EHB, the 2011 DOL report informed the subsequently adopted benchmark approach and the report’s findings served as a floor for EHB coverage in the individual and small group market. As a result, many current base-benchmark plan options generally provide a scope of EHB coverage that is equal to, or exceeds, the coverage typically provided in employer plans, as described in the DOL report.

As opposed to the current approach, the proposed typical employer plan definition completely ignores the 2011 DOL report and the whole concept of “typicality.” The definition merely provides that a typical employer plan is one whose enrollment exceeds 5,000 enrollees in one or more states and is silent as to the scope of coverage typically seen in employer-based plans. In other words, the definition bases typicality on enrollment in a single plan instead of comparability of benefits across multiple employer plans. We strongly believe that a definition of typical employer plan must be informed by the DOL report on medical benefits typically covered by employers, *which are measured by analyzing coverage across multiple employers*. By defining typical employer plan based solely on enrollment, the proposed approach contravenes the ACA’s requirement that the scope of EHB in the Marketplace be equal to the scope of “benefits typically covered by employers.”

The proposed definition would also have a practical detrimental effect on EHB coverage in the individual and small group market. While it is possible that certain employer plans with substantial enrollment provide coverage as comprehensive as coverage in typical employer plans, the proposed definition is broad enough to include plans with considerably less comprehensive coverage. Indeed, an employer plan with substantial enrollment that only covers preventive services would be considered a typical employer plan under the

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<sup>24</sup> Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services. April 15, 2011. Available at: <https://www.bls.gov/ncs/ebs/sp/selmedbensreport.pdf>.

proposed definition despite the fact that the plan fails to cover all other benefits that are typically covered by a majority of employers across the country.<sup>25</sup>

The proposed approach would also result in higher cost-sharing imposed on benefits covered by plans that are no longer considered EHBs, as the ACA's annual limit on cost-sharing only applies to EHBs. To the extent that a state elects a new benchmark plan with minimal coverage within each EHB category, all excluded services will not be subject to the ACA's protections against unreasonable cost-sharing. Thus, if a plan decides to cover services that now fall outside of the scope of EHB, they will be free to impose high cost-sharing on coverage, which will make it difficult for individuals with disabilities and enrollees with complex medical conditions to access these services.

The proposed typical employer definition would have major implications in states that elect a new benchmark plan pursuant to proposed § 156.111(a)(3). States selecting a new benchmark plan under this section would be constrained only by the requirement that the scope of EHB coverage be equal to the scope of benefits provided under a typical employer plan. If the federal definition of typical employer plan includes any employer-based plan based on enrollment without regard to the benefits typically provided, states may rush to select atypical large employer plans with skimpier benefits as their benchmark plan. This approach would undermine the ACA's EHB requirement because individual and small group plans in these states will no longer be required to provide coverage for certain services within EHB categories that are typically covered by employers and that are necessary for enrollees with disabilities and complex medical needs.

The proposed typical employer definition lowers this minimum requirement in a way that contravenes the requirements of the ACA and implicates the Americans with Disabilities Act. First, the definition ignores the 2011 DOL report that defines typicality of benefits among employers despite the fact that the ACA mandates the Secretary of HHS to use the report to inform this determination. Second, by defining typical employer using enrollment instead of typicality of benefits, this definition will open the door to plans with skimpier benefits, which will have a detrimental effect on the most vulnerable enrollees.

#### *Data Collection for States' EHB Benchmark Plans for 2019 Plan Year and Later*

While we appreciate that HHS has collected and posted plan documents for each of the EHB benchmark plans, and notes that it will continue to do so, many times these documents refer to additional documents for coverage details, such as a benefits schedule, which is not included. Also, as mentioned above, we have found that generally the

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<sup>25</sup> In states selecting an employer plan that only covers preventive care as their benchmark plan, states would be required to supplement the remaining EHB categories to comply with the ACA. However, in this situation, states may elect to add minimal benefits within the other EHB categories and would still be deemed to comply with the typical employer plan requirement under the proposed rule.

evidence of coverage or certificate of coverage documents are confusing or incomplete, and many times these documents include multiple amendments which make it difficult to determine covered benefits. The benefits and limits charts currently provided for each state along with plan documents are supposed to help with the review process, but the level of detail in the charts varies significantly from state to state, with most states simply indicating whether a benefit is covered. The charts for EHB benchmarks should provide an accurate picture of covered benefits and, thus, include specificity about covered benefits and limits. This way everyone will understand exactly what benefits are included in the benchmark plan and how they are covered. Also, with more detail, the charts could become a helpful tool for state regulators to ensure coverage of EHBs by health plans and issuers.

## § 156.115 – Provision of EHB

### *Substitution of Benefits*

We strongly oppose HHS' proposal to allow benefit substitution both within **and between** EHB categories. Unless prohibited by state law, issuers offering EHBs are currently permitted to substitute benefits that are 1) actuarially equivalent to benefits replaced and 2) within the same EHB category. As a result, issuers may substitute services that certain populations (*e.g.*, individuals with chronic conditions) need and replace them with actuarially equivalent services, which may be less costly and more likely to attract healthier populations. This will be exacerbated by HHS' proposed policy change that would allow substitution of benefits **between** EHB categories as well.

Allowing issuers to substitute benefits within **and between** EHB categories will result in coverage gaps and higher out-of-pocket costs for consumers in need of services that are substituted and not covered by the issuer. This will also make it difficult for consumers to compare health coverage options, making plan selection challenging. As mentioned above, HHS recognizes that this proposal would increase the burden on consumers as they would “need 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.”<sup>26</sup>

In addition, without a standard set of EHBs that issuers must cover, it is unclear how state regulators would ensure adequate coverage of EHBs. HHS notes that by allowing substitution between categories, states “may encounter difficulties in ensuring that all categories are filled in such a way that amounts to EHB”.<sup>27</sup> This will open the door for inadequate coverage of the ten EHB categories.

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<sup>26</sup> 82 Fed. Reg. 51131.

<sup>27</sup> *Id.*

In the proposed rule, HHS notes that it considered allowing states to set a range of EHBs and to allow issuers to offer plans within that range.<sup>28</sup> However, HHS determined that this option did not meet statutory requirements.<sup>29</sup> Similarly, allowing issuer substitution of benefits within **and between** EHB categories does not meet statutory requirements. While states have the option to adopt more stringent standards that limit or prohibit this type of substitution, only a few states have prohibited benefit substitution. We urge HHS to eliminate any provision allowing issuer flexibility to substitute benefits within EHB categories, and not allow substitution of benefits between categories.

### **§ 156.150 – Application to Stand-Alone Dental Plans Inside the Exchange**

HHS proposal to eliminate actuarial value (AV) standards for Stand-Alone Dental Plans (SADPs) raises concerns, especially for consumers in states whose EHB benchmark is less comprehensive than what is provided through one of the pediatric oral care benchmarks. HHS proposes this change so that “consumers [may] select from a greater variety of plans and find one that is more likely to meet their specific needs.”<sup>30</sup> But without these protections, SADP issuers may offer less coverage to consumers. If no AV standard exists, a dental insurer could offer a product that covers only the minimally required benefits but otherwise omits sufficient coverage for other necessary oral health care for children.

Perhaps more importantly, the elimination of AV standards would prevent consumers from easily understanding the value of marketplace offerings. We strongly believe that any policy enacted by HHS should continue to protect quality, value, and ultimate utility of coverage products. Without some up-front marker of plan value, it will be more difficult for consumers to accurately compare options. It is important to maintain a standard of value for consumers purchasing a SADP through marketplaces. Because all state marketplaces have 2018 plans available at the specified AV levels, we request that HHS maintain a minimum standard of 70% AV and require insurers to advertise plan AV as part of the marketplace shopping experience.

### **§ 155.210 – Navigator Program Standards**

We are dismayed at the proposed changes to reduce the number of required navigator entities in a state from two to one. The requirement to have two entities ensures that a state can have a general entity and one more tailored to specific needs within a state, whether that includes a focus on young adults, limited English proficient individuals, or other targeted populations. Further, removing the requirement that one entity be a community and consumer-focused non-profit is also troubling. Many of the individuals assisted by

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<sup>28</sup> 82 Fed. Reg. 51134.

<sup>29</sup> *Id.*

<sup>30</sup> 82 Fed. Reg. 51109.



navigator entities have complex situations and community and consumer-based entities are best suited to address their needs. They already have the experience working with these populations on a regular basis.

We also oppose the proposal to remove the requirement that a navigator entity maintain a physical presence in the Exchange service area. This is troubling on many different accounts. First, face-to-face assistance is often critical to obtain the trust of applicants and to help walk them through the various components of application, plan selection, resolving data matching inconsistencies, and perhaps assisting with appeals. Further, entities with a physical presence will better know their communities and be better able to serve them because they likely interact with the target populations on an ongoing basis and are able to build relationships that transcend the application process. Physically present entities remain available after open enrollment to provide assistance if questions arise, can assist in finding providers, can help consumers prepare for re-enrollment. Navigators do much, much more than merely enroll eligible individuals and having the community presence and building the ongoing relationships with consumers is critical to ensure all eligible consumers obtain and maintain health insurance. In particular, individuals with low health literacy (in addition to low literacy in general), low internet proficiency and who live in rural areas may face additional challenges in enrolling and rely on assisters to help complete enrollment. As HHS recognizes in the preamble, “we believe entities with a physical presence and strong relationships in their FFE service areas tend to deliver the most effective outreach and enrolment results.” (81 Fed. Reg. 51084). Given this recognition, it is appropriate to maintain the requirements that a navigator have a physical presence in the state in which it receives funding to assist consumers.

### **§ 155.305 – Eligibility Standards**

We strongly oppose the removal of the direct notification requirement as proposed. We have communicated our concerns to HHS about the notices related to the “failure to reconcile” (FTR) process. Our prior letter outlined concerns that the current notices do not meet the requirements of current regulations or constitutional due process. We are concerned that the proposed changes to this provision are being made solely to eliminate the regulatory notice requirements for direct notification. Even if HHS makes these changes, the Constitution still applies. *See, e.g., Goldberg v. Kelly*, 397 U.S. at 254 (1970). And in a practical matter, without proper notice, consumers who receive adverse information do not know why the action is being taken and do not have the information they need to access a hearing that will afford them the opportunity to explain why the agency’s decision is incorrect.<sup>31</sup>

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<sup>31</sup> *Gray Panthers v. Schweiker*, 652 F.2d 146, 168 (D.C. Cir. 1981) (without adequate notice of reasons for denial “hearing serves no purpose”).

Notices **must**, in no uncertain terms, include the details on which the decision is made to comply with constitutional requirements. As stated in a federal case specifically addressing the inclusion of financial calculations:

[The] public interest in assuring that health benefits will not be erroneously terminated or denied outweighs the State's competing fiscal and administrative concerns. *Any inconvenience the State might suffer is out-balanced by the State's and the recipient's interest in providing health benefits to those who cannot otherwise afford them. The Court concludes that in order to understand the government's reason for the termination or denial, specific financial information must be included where applicable in order that errors may be corrected.*<sup>32</sup> (emphasis added)

Thus, the FFM must issue direct individual notice upon a FTR and that notice must contain a statement of the intended action, reasons for the action, specific legal support for the action, an explanation of the individual's hearing rights, and rights to representation and to continued benefits.<sup>33</sup> It is insufficient to couch the information as one of three potential reasons for the consumer to sleuth out. The notice must be "reasonably calculated" to afford the individual a meaningful opportunity to present her side of the story.<sup>34</sup> The notice must not presume that the individual already has a basis for understanding the determination.<sup>35</sup> It is not sufficient for an individual to challenge a decision and eventually obtain the information that should have been in the initial notice or call to receive additional information.<sup>36</sup> The baseline protections are especially important in the context of an FTR check when information is retrieved from sources other than the individual and the individual cannot verify that correct information was used unless the information is contained in the notice.

Individuals who will lose their APTCs due to a failure to reconcile necessarily have limited incomes (since eligibility for APTCs is between 100-400% FPL) and many cannot afford the

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<sup>32</sup> *Rodriguez v. Chen*, 985 F. Supp. 1189, 1195 (D. Ariz. 1996).

<sup>33</sup> 42 C.F.R. §§ 431.206, .210.

<sup>34</sup> *Mallette v. Arlington Cnty. Emps. Supplemental Ret. Sys. II*, 91 F.3d 630, 640-41 (4<sup>th</sup> Cir. 1996).

<sup>35</sup> *Baker v. State*, 191 P.3d 1005, 1010 (Alaska 2008). *Cf. Kuehl v. Dep't of Soc. & Health Servs.*, 164 Wash. App. 1016 (2011)(holding the State did not violate Due Process by providing the individual multiple individualized documents and a notice that explained the State's determinations).

<sup>36</sup> *Allen v. Alaska Dep't of Health & Soc. Servs.*, 203 P.3d 1155, 1169 n. 68 (Alaska 2009) (citing *Vargas v. Trainor*, 508 F.2d 485, 489-90 (7<sup>th</sup> Cir.1974) (holding that benefit reduction and termination notices that did not provide reasons for the agency's action violated due process despite fact that recipients could call caseworkers to learn the reasons and stating that "[u]nder such a procedure only the aggressive receive their due process right to be advised of the reasons for the proposed action"); *Ortiz v. Eichler*, 616 F.Supp. 1046, 1062 (D.Del.1985) *aff'd*, 794 F.2d 889 (3d Cir.1986)); *see also Schroeder v. Hegstrom*, 590 F.Supp. 121, 128 (D.Ore. 1984), *Hill v. O'Bannon*, 554 F.Supp. 190, 197 (E.D.Pa. 1982) and *Vargas v. Trainor*, 508 F.2d 485.

luxury of paying for a benefit until they can determine what next steps they need to take to maintain APTCs. They need—and the Constitution requires—a notice that contains the legally required information that will allow them to decide whether to rectify the issue or perhaps challenge the determination and, if so, to present their claim in a timely and effective way.

We recognize that both HHS and IRS send notices to consumers regarding the FTR process. However, neither HHS nor IRS notices regarding FTR currently comply with due process requirements.

We further note that HHS mentioned in the preamble that the current 3-reason notification method has successfully resulted in tax filers for approximately 60 percent of households receiving the notification taking appropriate action to file a tax return and reconcile associated APTC. (81 Fed. Reg. 51086) HHS went on to note that because approximately 40 percent of households receiving the notification did not take appropriate action, HHS believes it is important for program integrity purposes that Exchanges discontinue APTC for tax filers who failed to file a tax return and reconcile after the notice was provided. Rather than jump to the conclusion that 40% of individuals did not take appropriate action because they were ineligible, an equally reasoned explanation is that these consumers did not receive adequate notice about why they might lose future APTCs and what that would mean for their ability to access affordable health insurance in the future. Given the insufficient clarity of the notices, it is probable and indeed likely, that the majority of the 40% failed to take action specifically because the notices did not comply with due process requirements.

HHS also noted that to discontinue APTC for consumers who failed to file a tax return and reconcile their income taxes, Exchanges would be required to establish a mechanism through which to notify tax filers without making an unauthorized disclosure of protected federal tax information (FTI). Doing so could be financially and operationally burdensome and out of proportion to the limited need for FTI handling in Exchange notice generation functionality. We do not believe it is out of proportion given the property interest consumers have in receiving APTCs. Further, HHS could maintain the current regulation which allows Exchanges to continue APTCs to those consumers to whom direct notification is not possible given FTI requirements.

We do agree with HHS statement “improving the clarity and overall effectiveness of this notification process is a priority, and we continue to explore ways to make the process even more robust and consumer-friendly, without unduly burdening the Exchanges,” (81 Fed. Reg. 51086). We have previously provided suggestions on improving notices (including the eligibility determination notice, FTR notices, and MOEN) and urge HHS to work on improving notices rather than adopting the proposed regulation.

## § 155.320 – Income Inconsistencies

We oppose HHS' proposal to generate income inconsistencies for consumers whose attested projected annual income is greater than the income amount represented by federal data sources if the attested income is over 100% FPL while the returned data source indicates an income under 100% FPL.

HHS provides a patently false explanation of why this would be “helpful” to consumers: “This proposal also would help limit tax filers’ potential liability at tax reconciliation to repay excess APTC.” (81 Fed. Reg. 51086). Any consumer who attests to income above 100% FPL but ends the year with an actual income below 100% FPL is **exempt** from repaying excess APTCs. No consumer in this situation will have any tax liability if they receive APTCs during the year. In fact, many consumers may actually be financially worse off if they over-estimated their income because in most states they could have otherwise been eligible for Medicaid, which has lower cost-sharing, no deductibles, and often no premiums. Thus, consumers who accidentally over-estimated their income and received tax credits should not be penalized for this fact.

As we have seen over the course of five open enrollment periods, low-income consumers often face difficulty estimating their annual incomes. They may have fluctuating income due to shift work, seasonal work, time off needed for child/elder care, or a host of other reasons. We should not further penalize them by creating a data inconsistency which will require the individual to provide additional information to resolve. Additionally, the “trusted” data sources are often 1-2 years old and many consumers may have received a rise in their incomes for legitimate reasons merely due to the passage of time or perhaps because they live in an area where minimum wage laws have increased hourly wages. Or, they may have changed jobs that should not necessitate proving why their current income is likely higher than their prior income. In fact, we should be celebrating rather than penalizing the fact that these consumers estimate that their income has risen above the federal poverty level.

Secondly, the administrative burdens to Exchanges for having to request, obtain, and verify this income data outweigh any other alleged concerns. Consumers already have the responsibility to report changes in income throughout the year and should not face increased verification at the application stage when they already have to attest that their estimate is as accurate as possible.

Given that individuals do not face any financial penalties if they receive APTCs for estimating an income above 100% FPL if their year-end income actually is below, and that additional burdens to proving income will likely dissuade or prevent eligible individuals from enrolling in care, we strongly recommend that HHS keep the current regulations regarding income inconsistencies.

## **§ 155.335 – Annual Eligibility Determinations**

HHS seeks comments on whether allowing HHS to access tax data for 5 years should be shortened. We do not support shortening this time period. Under current requirements, many individuals can find themselves ineligible for APTCs if they do not authorize HHS to check their tax data. For consumers who choose to allow HHS to access tax data with the expectation that it will ease the requirements for reenrollment, shortening this period will only add a new responsibility on consumers to have to authorize access in shorter intervals. As it is, accessing tax data may not provide consumers with accurate information if their job or income changes and they may receive lower APTCs upon re-enrollment if they do not affirmatively update their income but instead allow HHS to rely on tax data. At least these consumers will continue to have access to health insurance. If the time period were shorter, consumers may not receive any APTCs at reenrollment unless they affirmatively renew their approval to access tax data.

Individuals already have other requirements to update their applications on a regular basis to reflect other changes in circumstances that affect eligibility (such as changes in income or marital status). If consumers are comfortable allowing HHS to access their tax data for five years, consumers should be able to do so and not have to update their assent more times just to continue to receive APTCs for which they are eligible. The administrative costs this would entail – having to affirmatively ask consumers to approve access to tax data on a shorter time period – would likely outweigh any benefits.

## **§ 155.420 – Special Enrollment Periods**

We support the proposed changes related to dependents as well as excluding the SEP in paragraph (d)(12) from paragraph (a)(4)(iii). Certainly if information about a plan or benefit has a material error, an individual should be allowed to select a new plan from any metal level and should not be limited to the metal level in which the individual originally enrolled.

We also support the proposal to amend paragraph (a)(5) to exempt qualified individuals from the prior coverage requirement if, for at least 1 of the 60 days prior to the date of their qualifying event, they lived in a service area where there were no QHPs offered through an Exchange. As HHS noted, without this change, certain qualified individuals who have lived for part of the benefit year in a location where no QHPs were offered, and were unable to enroll in minimum essential coverage, would be prevented from subsequently qualifying for a special enrollment period due to a permanent move or marriage. We believe this is a valid interpretation of HHS' Special Enrollment Period authority.

We also support the proposal to remove paragraph (b)(2)(v) of this section and to revise paragraph (b)(2)(i) to include the special enrollment period for a court order to align the coverage effective dates for all special enrollment periods based on gaining or becoming a dependent (except gaining or becoming a dependent through marriage). We do note,

however, that our support for this regulation is conditioned on HHS retaining the ability of the qualified individual or enrollee to elect a coverage effective on the first of the month following plan selection, rather than the month following the qualifying event, as currently written, or following regular coverage effective dates, in accordance with paragraph (b)(1) of this section.

We do not support the overall concept of providing health coverage to fetuses, instead of providing needed care directly to pregnant women. Pregnant women, and all women, are deserving of quality comprehensive health care. However, we also recognize this coverage option is currently allowed through the Children's Health Insurance Program and allows pregnant women, who are often ineligible for Medicaid, to access essential prenatal care. We do support allowing women receiving care through the CHIP fetus option to receive a hardship exemption so that they are not required to also maintain minimum essential coverage during the time they are covered through their fetus. We also support providing these women with a Special Enrollment Period when the CHIP coverage expires so that they have an ability to enroll in other coverage if they are eligible.

We also support the technical correction to update the cross-reference to 26 C.F.R. 1.36B-2T that finalized the special enrollment period for survivors of domestic abuse or spousal abandonment.

### **§ 155.430 – Effective Dates for Termination**

We support the proposed changes to make it easier for consumers to request a specific termination date. As HHS notes, “allowing enrollees to terminate their coverage immediately or on a future date of their choosing also would provide consumers with greater control over ending their QHP coverage and would help minimize or eliminate overlaps in coverage”. (81 Fed. Reg. 51091). This issue has been particularly vexing for individuals enrolled in marketplace coverage who are transitioning to Medicare. Sometimes Call Center Representatives let these individuals cancel prospectively, other times they tell individuals to cancel on the day before Medicare becomes effective. Individuals should be able to prospectively cancel their coverage without having to call back multiple times or worry about penalties for having dual coverage if they forget to call back if they originally called in a timely manner. We support the elimination of the 14-day “reasonable notice” requirement. This insurer option often led to delayed terminations with coverage extending into the next month when people had other MEC and were ineligible for PTC, causing headaches when the credit was reconciled. Insurers can and should make same-day or next-day terminations at the consumer's request. Same day terminations are particularly important when people cancel on the last day of the month.

The rule also proposes to align QHP termination rules for people who become eligible for Medicaid, CHIP and the basic health plan with the other termination rules. We understand the confusion between payers that may result when QHPs are terminated



retroactively. However, we are concerned that eliminating this provision will require consumers — instead of the marketplace — to initiate QHP terminations when consumers are determined eligible for Medicaid or CHIP. Many individuals who have only interacted with the marketplace to get their Medicaid or CHIP determination assume that information is shared across programs and do not understand the requirement to cancel QHP coverage. If consumers fail to terminate QHP coverage, they will be ineligible for PTC in the months following the Medicaid determination, will not pay a premium because they are enrolled in Medicaid and will have coverage terminated through a grace period. Yet at the end of the grace period, they will still owe the full premium for one month of coverage after the Medicaid determination. Under the new guaranteed issue interpretation, the QHP issuer could deny coverage in the following year unless the premium from the first month of the grace period is paid. We are concerned that putting the full responsibility for QHP termination on the consumer will lead to more terminations during grace periods and consumers falling into arrears with insurers, which could prevent future enrollment for some consumers.

### **§ 156.230 – Establishment of Exchange Network Adequacy Standards**

We oppose HHS’s proposal to rely on state regulators to ensure network adequacy, rather than performing its own network adequacy review. HHS proposes to allow state regulators to certify QHP network adequacy so long as HHS determines that the state has the authority to ensure “reasonable access” to providers and the capacity to assess the sufficiency of plans’ networks. In states where regulators lack this capacity, HHS proposes to rely on private accreditation of health plans rather than evaluate network adequacy itself. HHS does not propose to change existing network adequacy regulations, but rather, professes an intention to change sub-regulatory policy as to their implementation

Network adequacy protections are critical in making the promise of care in the ACA real. NHeLP has written extensively about the importance of network adequacy for low-income consumers, in particular.<sup>37</sup> The consumer experience in QHPs over the last three years has spotlighted a need for additional regulatory standards governing network adequacy. Consumers in the first three open enrollment periods struggled mightily to understand which providers would accept the QHP options available to them. Even after enrollment, many consumers were not able to find providers willing to provide them with needed care.<sup>38</sup>

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<sup>37</sup> See, e.g., NHELP, NETWORK ADEQUACY LAWS IN COVERED CALIFORNIA PLANS (2014), *available at* <http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/network-adequacy-laws-in-covered-california-plans-issue-No-2>; NHELP, MEDICAID MANAGED CARE MODEL PROVISIONS: NETWORK ADEQUACY (2014), *available at* <http://www.healthlaw.org/publications/browse-all-publications/medicaid-managed-care-model-provisions-issue-3>; NHELP, NETWORK ADEQUACY IN MEDICAID MANAGED CARE: RECOMMENDATIONS FOR ADVOCATES (2013), *available at* <http://www.healthlaw.org/issues/medicaid/network-adequacy-in-medicicaid-managed-care>.

<sup>38</sup> For example, one New York case alleges that a QHP enrollee called more than 30 primary care doctors during September and October, 2014, but was unable to find a single one in his New York

During this open enrollment period, consumers have experienced difficulty—often with the potential for dire consequences to their health—finding a plan that contracts with the providers they need. For example, one Virginia family recently discovered that they do not have any plan choices this year that contract with the specialists their four year-old daughter, who is battling leukemia, requires.<sup>39</sup> And other consumers received large bills for services rendered that they believed their QHP would cover. One recent study found that nearly 15% of Silver plans sold on healthcare.gov in 2015 did not contract with any in-network physicians for at least one medical specialty area.<sup>40</sup> More regulation in this area is sorely needed—not a regulation that essentially deems a network adequate if a state has the authority and capacity to determine adequacy—even if it never does it.

Strong HHS regulation of QHP networks is especially warranted since QHPs serve a comparatively vulnerable population. HHS estimates that, as of January 2017, 81% of QHP enrollees this year were receiving financial assistance, indicating that they are under 400% FPL.<sup>41</sup> Moreover, at the end of open enrollment for 2017, QHPs had already enrolled just over 800,000 children under age 18, and over 2.5 million adults aged 55 and older; these populations are likely to have special health care needs.<sup>42</sup> During open enrollment for 2016, QHPs enrolled over 3 million women between the ages of 18 and 54.<sup>43</sup> A recent report from California noted that 20% of 2016 Exchange enrollees selected a non-English language as their preferred language.<sup>44</sup> Similarly, a report on 2016 enrollment in New York’s Exchange found that 20% of enrollees there selected a language other than English as their preferred language.<sup>45</sup>

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City ZIP code that accepted his QHP and was seeing new patients. See Complaint at ¶¶ 16-124, *Fougnier v. Empire Blue Cross*, No. 159791(N.Y. Sup. Ct. Oct. 6, 2014).

<sup>39</sup> Colby Itkowitz, *Parents of 4-Year-Old with Cancer Can’t Buy ACA Plan to Cover Her Hospital Care*, WASH. POST, Nov. 15, 2017, [https://www.washingtonpost.com/local/parents-of-4-year-old-with-cancer-cant-buy-aca-plan-to-cover-her-hospital-care/2017/11/15/a3ba6fb6-c56d-11e7-aae0-cb18a8c29c65\\_story.html](https://www.washingtonpost.com/local/parents-of-4-year-old-with-cancer-cant-buy-aca-plan-to-cover-her-hospital-care/2017/11/15/a3ba6fb6-c56d-11e7-aae0-cb18a8c29c65_story.html).

<sup>40</sup> Stephen C. Dorner *et al.*, *Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act*, 314 J. AM. MED. ASS’N 16 (2015).

<sup>41</sup> DEPT. HEALTH & HUMAN SERVS., OFFICE OF THE ASST. SECT’Y FOR PLANNING AND EVALUATION, HEALTH INSURANCE MARKETPLACES 2017 OPEN ENROLLMENT PERIOD: JANUARY ENROLLMENT REPORT 3 (2017), <https://downloads.cms.gov/files/final-marketplace-mid-year-2017-enrollment-report-1-10-2017.pdf>.

<sup>42</sup> *Id.*

<sup>43</sup> DEPT. HEALTH & HUMAN SERVS., OFFICE OF THE ASST. SECT’Y FOR PLANNING AND EVALUATION, HEALTH INSURANCE MARKETPLACES 2016 OPEN ENROLLMENT PERIOD: MARCH ENROLLMENT REPORT 31 (2016), <https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf>.

<sup>44</sup> Covered Cal. & Cal. Dept. Health Care Servs., *Covered California Data and Research: Language spoken by subsidy status* (2016),

<sup>45</sup> NY STATE OF HEALTH, 2016 OPEN ENROLLMENT REPORT 18 (2016), <https://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202016%20Open%20Enrollment%20Report%282%29.pdf>.

The ACA requires the Secretary of HHS to establish network adequacy requirements for health insurance issuers seeking certification of QHPs. ACA § 1311(c)(1)(B). These proposed regulations would delegate that authority to individual states regulators rather than establish a uniform standard. As a legal matter, there is no authority in the ACA for delegating the duty to establish network adequacy standards to the Exchanges. As a matter of policy, delegating network adequacy monitoring and enforcement to state regulators and private accreditation bodies is likely to result in little assurance that networks are truly adequate. In terms of state regulators, a 2014 Survey on State Insurance Standards prepared for the National Association of Insurance Commissioners found that only a few states enforced network adequacy standards.<sup>46</sup> Specifically, less than 10% of state regulators reported performing “secret shopper” calls to check whether providers listed in plan directories had capacity to take on new patients and were contracted with the plan.<sup>47</sup> Similarly, only 6% of regulators reported that they had taken more than one enforcement action to correct network adequacy problems in the preceding year.<sup>48</sup> Where private accreditation bodies are in charge of enforcing network adequacy, enforcement is even less likely. The private accreditation process generally uses a self-certification method for determining network adequacy, so plans set and assess compliance with their own standards.<sup>49</sup> Private accreditation bodies “have virtually no method of enforcing such standards beyond revoking or suspending an insurer’s accredited status.”<sup>50</sup> By delegating network adequacy review and enforcement to state regulators and private accreditation bodies, HHS ignores the fact that these entities are not equipped to ensure that consumers have access to necessary care as required by the ACA. HHS should not make the proposed change.

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<sup>46</sup> See generally HEALTH MANAGEMENT ASSOCIATES, ENSURING CONSUMERS’ ACCESS TO CARE: NETWORK ADEQUACY STATE INSURANCE SURVEY FINDINGS AND RECOMMENDATIONS FOR REGULATORY REFORMS IN A CHANGING INSURANCE MARKET (2014), [http://www.naic.org/documents/committees\\_conliaison\\_network\\_adequacy\\_report.pdf](http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf); see also JANE B. WISNER & JEREMY MARKS, URBAN INST., ENSURING COMPLIANCE WITH NETWORK ADEQUACY STANDARDS: LESSONS FROM FOUR STATES 9 (2017) (describing remaining “[c]hallenges . . . in assessing and monitoring network adequacy”), [https://www.urban.org/sites/default/files/publication/88946/2001184-ensuring-compliance-with-network-adequacy-standards-lessons-from-four-states\\_0.pdf](https://www.urban.org/sites/default/files/publication/88946/2001184-ensuring-compliance-with-network-adequacy-standards-lessons-from-four-states_0.pdf); MARK A. HALL & PAUL B. GINSBURG, BROOKINGS INST., A BETTER APPROACH TO REGULATING PROVIDER NETWORK ADEQUACY 7 (2017) (“Once regulators approve an insurer’s network adequacy plan, typically they then leave it to insurers to self-monitor their own compliance. Rather than conducting routine audits or requiring periodic reports of actual compliance, state regulators usually rely on consumer complaints to highlight situations that might require investigation”), <https://www.brookings.edu/wp-content/uploads/2017/09/regulatory-options-for-provider-network-adequacy.pdf>.

<sup>47</sup> See HEALTH MANAGEMENT ASSOCIATES, *supra*, note 46, at 25.

<sup>48</sup> See *id.* at 27.

<sup>49</sup> Mark Hall & Caitlin Brandt, *Network Adequacy Under the Trump Administration*, HEALTH AFFAIRS BLOG (Sept. 14, 2017), <http://www.healthaffairs.org/doi/10.1377/hblog20170914.061958/full>.

<sup>50</sup> *Id.*; see also HALL & GINSBURG, *supra*, note 46 at 7 n.27 (describing the process used by the largest such accreditation body, the National Committee for Quality Assurance (NCQA)).

## § 156.235 – Essential Community Providers

The requirement that QHP networks must contract with Essential Community Providers (ECPs) who provide care to predominately low-income and medically-underserved populations is key to improving health outcomes and reducing health and health care disparities<sup>51</sup>. Since QHPs serve large numbers of women of childbearing age, it is also crucially important that HHS ensure that their networks include ECPs that can serve the unique health needs of women.<sup>52</sup> Overall, we have been pleased by the strides HHS has taken toward ensuring participation by the full range of ECPs that currently comprise the safety-net of providers who provide health care to low income communities. We oppose HHS's proposals that will reduce ECP participation.

We oppose HHS's proposal to reduce the percentage of ECPs included in QHP networks to 20%. HHS has required QHPs in the FFM to comply with a 30% threshold for the past three years, and compliance has not caused any hardship to QHPs. Non-profit and publicly funded clinics are critical to overall and reproductive health of low income individuals. Access to family planning clinics allows women to prevent unintended pregnancies. A total of 6.2 million women received publicly funded family planning services from 10,700 clinics in 2015. Unintended pregnancies are declining – especially among adolescents. Without access to local, trusted, publicly funded community-based clinics, the unintended pregnancy rate would be 31% higher for adult women, and 44% higher for adolescents.<sup>53</sup>

Still there is more to be done. While birth rates for females aged 15-19 have declined eight percent overall, disparities persist for communities of color. In 2015, Latina teens (females ages 15 to 19) experienced birth at more than twice the rate of their non-Hispanic, white peers. For the same year, Alaska Native/American Indian teens experienced birth at more than one and a half times the rate of their non-Hispanic, white peers.<sup>54</sup>

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<sup>51</sup> CRISTINA JADE PEÑA *ET. AL.*, KAISER FAMILY FOUND., FEDERAL AND STATE STANDARDS FOR “ESSENTIAL COMMUNITY PROVIDERS” UNDER THE ACA AND IMPLICATIONS FOR WOMEN’S HEALTH, Kaiser Family Foundation (2015), <http://files.kff.org/attachment/issue-brief-federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health>.

<sup>52</sup> During open enrollment for 2016, QHPs enrolled over 3 million women between the ages of 18 and 54. DEPT. HEALTH & HUMAN SERVS., OFFICE OF THE ASST. SECT’Y FOR PLANNING AND EVALUATION, HEALTH INSURANCE MARKETPLACES 2016 OPEN ENROLLMENT PERIOD: MARCH ENROLLMENT REPORT 31 (2016), <https://aspe.hhs.gov/system/files/pdf/187866/Finalenrollment2016.pdf>.

<sup>53</sup> JENNIFER J. FROST *ET AL.*, GUTTMACHER INST., PUBLICLY FUNDED CONTRACEPTIVE SERVICES AT U.S. CLINICS, 2015, (2017), <https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015>.

<sup>54</sup> CENTERS FOR DISEASE CONTROL AND PREVENTION, SOCIAL DETERMINANTS AND ELIMINATING DISPARITIES IN TEEN PREGNANCY, <https://www.cdc.gov/teenpregnancy/about/social-determinants-disparities-teen-pregnancy.htm> (last updated Oct. 26, 2017).

Furthermore, a significant number of safety net providers within every network is essential to better birth outcomes. **People of color face significant barriers in access to and utilization of care.**<sup>55</sup> Nonelderly Asians, Hispanics, Blacks, and American Indians and Alaska Natives face increased barriers to accessing care compared to Whites and have lower utilization of care. For example, the preterm birth rate for Black women is 24% – higher than for any other women. Black women experience higher rates of certain chronic conditions such as diabetes, hypertension, and sexually transmitted infections, which can result in poor birth outcomes if these conditions are remain unidentified or unmanaged before women become pregnant.<sup>56</sup> In 2015, the infant mortality rates were 5.0% for Hispanic, 8.3% for American Indian/Native Alaskans, 11.3% for Non-Hispanic Black, compared to 4.9% for non-Hispanic Whites. More ECPs, not fewer, are critical to meeting the needs of these communities.

In Appalachia, the life expectancy is 13 years shorter than the rest of the U.S. Communities in Appalachia experience greater rates of adult smoking, obesity, physical inactivity, disability, and diabetes. They also experience higher rates of preterm birth, low birthweight, maternal diabetes, and maternal hypertension.<sup>57</sup> All of these conditions are indicators of greater need for medical services, yet Appalachia also faces a shortage of providers. Weakening the ECP standard will only exacerbate these concerns.

We are also deeply concerned that the proposed rule would severely weaken the ECP standards by no longer requiring state-based exchanges utilizing the federal platform to enforce ECP standards that are used for federally facilitated exchanges. Already, some state-based exchanges that do not use the federal platform have adopted less robust ECP standards.<sup>58</sup> Consumers in these states may have less access to providers that serve women of reproductive age and enrollees of color.<sup>59</sup> Robust standards are needed to ensure that plans are providing access to the ECPs on which these communities rely.

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<sup>55</sup> SAMANTHA ARTIGA, et. al., THE HENRY J. KAISER FAMILY FOUNDATION, KEY FACTS ON HEALTH AND HEALTH CARE BY RACE AND ETHNICITY (Jun. 07, 2016), <https://www.kff.org/disparities-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity>.

<sup>56</sup> MARCH OF DIMES, PREMATURE BIRTH REPORT CARDS, <https://www.marchofdimes.org/mission/prematurity-reportcard.aspx>.

<sup>57</sup> Gopal K. Singh et.al., *Widening Disparities In Infant Mortality And Life Expectancy Between Appalachia And The Rest Of The United States*, 1990–2013, 36 HEALTH AFFAIRS 1423-32 (Aug. 2017).

<sup>58</sup> See, e.g., KAISER FAMILY FOUND., CONTRACT OFFERING AND SIGNING STANDARDS FOR ESSENTIAL COMMUNITY PROVIDERS (ECPs) IN MARKETPLACES (2016), <https://www.kff.org/other/state-indicator/contract-offering-and-signing-standards-for-essential-community-providers-ecps-in-marketplaces>.

<sup>59</sup> See PEÑA ET. AL., *supra*, note 51 at 2-3.



In addition, HHS states that it will continue to allow issuers to use the ECP write-in process to identify ECPs that are not on the HHS list of available ECPs. We urge HHS to eliminate this option that permits issuers to forgo the ECP standard completely by submitting a narrative justification that describes why they could not meet the standard but still have a network that is sufficient to meet the needs of low-income and medically underserved enrollees. This provision has the potential to become the exception that swallows the rule. Without an adequate number of actual ECPs in an issuer's network, women and communities of color who rely on ECPs for their care will have less access to the care they need.

### **Subpart C – Qualified Health Plan Certification**

We recognize that the ACA provides opportunities for state flexibility in some implementation areas. However, that flexibility should not apply to monitoring and enforcing the ACA's non-discrimination provisions.

HHS previously has described a number of plan review and monitoring activities to help determine whether plan benefit designs comply with the ACA non-discrimination provisions. However, in the proposed rule, HHS states that it wishes to streamline the QHP certification process and further devolve plan review and monitoring to state authorities.<sup>60</sup>

We urge HHS to employ a broad, multi-prong approach to non-discrimination compliance monitoring and enforcement that includes effective methodologies and robust national standards to assess plan benefit design. Reliance on state monitoring and enforcement of non-discrimination protections leads to disparate health care access and quality, whereby a plan benefit design may be considered compliant by one state but found non-compliant by another state.

The ACA contains additional protections for individuals by barring discriminatory plan benefit design, establishing that a QHP may “not employ marketing practices or benefit designs that *have the effect of discouraging the enrollment in such plan by individuals with significant health needs.*”<sup>61</sup> A QHP fails to meet the EHB standard if its benefit design discriminates based on an “individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions” and can be decertified from participation in the Exchange.<sup>62</sup> This is reiterated in HHS' regulations.<sup>63</sup>

However, despite these robust protections, some QHPs continue to discriminate against individuals with disabilities and those with serious or chronic medical conditions. In 2014, NHeLP and The AIDS Institute filed a HIV/AIDS discrimination complaint with the HHS

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<sup>60</sup> 82 Fed Reg 51109.

<sup>61</sup> 42 U.S.C. § 18031(c)(1)(a) (emphasis added); see also 45 C.F.R. § 156.225(b)).

<sup>62</sup> 45 C.F.R. § 156.125(a).

<sup>63</sup> 45 C.F.R. § 156.125(a).



Office for Civil Rights (OCR) against four Florida issuers that placed all HIV medications, including generics, in the highest tier. By placing even generic drugs on the top tier, patients faced high up-front costs in the form of expensive co-insurance and co-pays, as well as burdensome prior authorization requirements and quantity limits. These tactics are particularly hazardous for people living with HIV/AIDS. Gaps in anti-retroviral treatment can lead to the development of drug resistance and increased rates of new HIV infections.

In a study published in the *New England Journal of Medicine* in January 2015, *Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace*, researchers at the Harvard School of Public Health examined 48 ACA health plans and found that a dozen of these plans placed medications used to treat HIV/AIDS in the highest cost-sharing tiers.<sup>64</sup> This practice — known as “adverse tiering” —serves to discourage people with significant health needs from enrolling in the health plan.

The National Alliance on Mental Illness (NAMI) also identified adverse tiering for medications used in the treatment of mental illness in its 2015 report: *A Long Road Ahead — Achieving True Parity in Mental Health and Substance Use Care*.<sup>65</sup> NAMI commissioned a study of formularies for 84 health plans to assess coverage of three classes of psychiatric medications: antipsychotics, antidepressants, and SSRIs/SNRIs used commonly to treat depression. The analysis found that many plans placed these medications on high cost sharing tiers or with restricted access.<sup>66</sup>

Adverse tiering can have serious consequences by impeding access to potentially life-saving medications. Adverse tiering works for insurers by steering persons with significant health needs, such as HIV/AIDS, away from their plans. As a result, plans with more balanced tiering structures become more likely to enroll high-need patients. Consequently, the health plan’s enrollment could become imbalanced, placing pressure on the health plan to change its coverage policies or raise premiums and/or deductibles. This can lead to a “race to the bottom” effect where Marketplace plans all start putting these medications in the highest-cost tiers. Meanwhile, people who most need coverage are left with few options.

Adverse tiering, like adverse selection or “cherry picking” healthier enrollees, is prohibited under the ACA. HHS recognized this in previous rulemakings and guidance, most recently in the 2017 Letter to Issuers, stating, “if an issuer places most or all drugs that treat a specific condition on the highest cost formulary tiers, that plan design might effectively

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<sup>64</sup> Douglas B. Jacobs, Sc.B., and Benjamin D. Sommers, M.D., Ph.D., *Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace*, *N ENGL J MED* 399-402 (Jan. 29, 2015).

<sup>65</sup> NAMI, *A Long Road Ahead — Achieving True Parity in Mental Health and Substance Use Care* (April 2015) at 7; available at <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf>.

<sup>66</sup> *Id.*

discriminate against, or discourage enrollment by, individuals who have those conditions.”<sup>67</sup> In the 2018 Letter to Issuers, HHS reiterates its concern about adverse tiering and proposes to review tiering of drugs used in the treatment of high-cost, chronic medical conditions.<sup>68</sup>

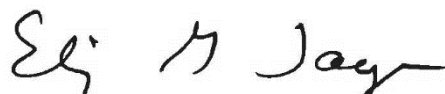
Compliance reviews serve an important role in ensuring that issuers meet EHB and other standards. NHeLP strongly supports strengthening the compliance review process and allowing for sanctions on issuers that are non-responsive or uncooperative with the compliance reviews. We also urge HHS to make the results of its compliance reviews publicly available on an ongoing basis rather than posting a year-end summary report.<sup>69</sup> Health care consumers and advocates could greatly benefit from more detailed information revealed by compliance reviews when assessing plan performance, including issuers and plans subject to targeted, expedited reviews when CCIO has identified potential harm to consumers.

HHS has made tremendous progress establishing tools and guidance to review plans for compliance with non-discrimination protections. We oppose efforts to weaken those standards and monitoring efforts.

## Conclusion

Thank you for your attention to our comments. If you have any questions or need any further information, please contact Mara Youdelman, Managing Attorney ([youdelman@healthlaw.org](mailto:youdelman@healthlaw.org); (202) 289-7661).

Sincerely,



Elizabeth G. Taylor  
Executive Director

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<sup>67</sup> CCIO, 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 29, 2016) at 45; available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf>.

<sup>68</sup> CCIO, 2018 Letter to Issuers in the Federally-facilitated Marketplaces (Dec. 16, 2016) at 46; available at <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>.

<sup>69</sup> 2017 Letter to Issuers at 60, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf>; 2018 Letter to Issuers at 43, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>.