



November 27, 2017

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

Society for Public Health Education's (SOPHE) comments on the proposed rule Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2019 (CMS-9930-P)

Dear Administrator Verma:

The Society for Public Health Education welcomes the opportunity to comment on the CMS proposed rule regarding benefit and payment parameters for 2019 for the Patient Protection and Affordable Care Act. Stable markets that offer Americans adequate choice, benefits, and affordability in the health insurance markets are critical to meaningful access to health care for all Americans.

The Society for Public Health Education (SOPHE) is a 501 (c)(3) professional organization founded in 1950 to provide global leadership to the profession of health education and health promotion. SOPHE contributes to the health of all people and the elimination of health disparities through advances in health education theory and research; excellence in professional preparation and practice; and advocacy for public policies conducive to health. SOPHE is the only independent professional organization devoted exclusively to health education and health promotion. Members include behavioral scientists, faculty, practitioners, and students engaged in disease prevention and health promotion in both the public and private sectors. Collectively, SOPHE's national and chapter members work in universities, medical/health care settings, businesses, voluntary health agencies, international organizations, and all branches of federal/state/local government.

Comments on Proposed Rule

While SOPHE appreciates the need for states to have some measure of flexibility in designing health insurance mechanisms tailored to the state's population, SOPHE cautions that allowing states to define essential health benefits could result in a patchwork system of health coverage in which some states have excellent and well-defined coverage while others offer their citizens little in exchange for their premium payments. SOPHE is very concerned that the proposed changes to how states can select their essential benefits will diminish patient care and increase beneficiary's out of pocket costs. Given that the federal government is subsidizing these premium payments, it has a role and a fiscal responsibility to ensure that states are providing adequate coverage, hence the federally defined essential health benefits package. SOPHE is disappointed that Health and

Human Services (HHS) is abandoning the “standardized plan option” in the federally-facilitated market. These plans are working well in many states and allow beneficiaries to access benefits with set co-pays and often exempt prescription drugs from the deductible or have a separate, lower prescription drug deductible. Additionally, while this may reduce the burden of health plans from duplicative state and federal plan reviews it will increase each issuer's complexity when dealing with multiple states with differing minimum requirements. This could also precipitate less competition in the market as insurers elect to only offer plans in states with less stringent requirements. Allowing states to select benchmark plans from other states, or to select benefit categories from another state's benchmark plan runs counter to meeting the needs of beneficiaries in that state. SOPHE cautions that giving states an almost endless combination of services under the pretext of state flexibility creates the opportunity to reduce beneficiary health benefits and increase patient out of pocket cost sharing. For these reasons, SOPHE urges HHS to abandon the proposed options and maintain the current process for states to select their essential health benefits.

There is already ample flexibility for states with states currently having 10 benchmark plans to select from each year to help define that state's essential health benefits package. This current system meets the legal requirement of the Affordable Care Act that the essential health benefits be similar to a typical employer plan operating in the state. Constructing the benchmark plan by cherry picking benefit categories will create a plan that does not resemble any existing plan in the marketplace today. These options would allow states to reduce or weaken beneficiary benefits because states can find plans and categories of benefits anywhere in the country and select the least comprehensive suite of benefits to create scaled back coverage requirements. This would be particularly true for the proposed third option, which would allow a state to create a new benchmark plan from scratch that must be less generous than the most generous among a set of comparison plans. These proposals for selecting benchmark plans and categories will discourage states from offering comprehensive coverage because they would be responsible for defraying the costs beyond a minimal threshold of benefits. New benchmark plans that curtail benefits will mean a higher cost sharing burden and out of pocket expenses for patients. The problem is compounded because benefits that are not covered do not count toward out of pocket maximums. The current process provides states sufficient options and reflects the individual needs of the state. In fact, 7 of the 10 benchmark plans that states can currently select are state-specific plans. Additionally, states can select from the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment.

SOPHE also opposes the proposed abandonment of the “meaningful difference” standard and would urge the department to reconsider this proposal. Several states that run their own marketplace have successfully implemented standard plans. SOPHE believes that consumers can benefit from being able to more easily compare plans across issuers and have some level of protection through cost-sharing limits, particularly for prescription medications, as well as exempting drugs in most metal levels from the deductible. Deductibles and other patient cost-sharing have increased to such a point that accessing health care, and particularly prescription medications, has become difficult for many patients. The use of standardized plans can help reduce the cost-sharing burden for patients and allow them to actually utilize their health insurance. SOPHE does not share HHS's concerns that standardized plans stifle innovation because there is no requirement that issuers offer them, and issuers are allowed to offer other plans. Shopping and selecting a plan that best meets a patient's health needs and which they can afford is not an easy process. Ensuring that plans are in fact meaningfully different reduces confusion and helps improve the beneficiary shopping experience. SOPHE disagrees with the

assertion that the current meaningful difference standard limits innovation and believes the existence of such a standard encourages greater innovation and differences among plans.

As stated in the proposed rule, the Affordable Care Act contains important patient protections that help in defining essential health benefits and that all issuers must abide by when designing benefit plans and that plan benefit design cannot discriminate based on an individual's age or disability. The essential health benefits must also consider the health needs of diverse segments of the population including women, children, persons with disabilities, and other groups. Continuation of these patient protections is critical so that qualified health plans meet the needs of patients, particularly those with serious and chronic conditions. SOPHE is concerned that in an effort to provide greater state flexibility some states will not enforce these important patient protections, eroding beneficiaries' access to quality healthcare. Many states lack the financial resources and/or legal authority to prospectively review plans and formularies to ensure that they are adequate and do not discriminate against beneficiaries. Some states have stated that they have no interest in or a limited capacity to implement plan requirements included in the Affordable Care Act, including these important patient protections. SOPHE encourages HHS to fully enforce the patient protections contained in the law and in regulation, and ensure that if oversight or enforcement responsibilities are assumed by the states, they have the authority and resources necessary to fully address patient protections, particularly nondiscrimination in benefit design.

Since the inception of the Affordable Care Act, navigators have served the critical role of providing consumers with in-person assistance with eligibility questions, marketplace applications and enrollment, maintenance of coverage, and accessing care once coverage has been achieved. SOPHE has a number of concerns with the proposal to eliminate the requirement that each Exchange must have at least 2 navigator programs, one of which must be a community and consumer focused nonprofit. Navigators that come from the community in which they serve are uniquely qualified to understand the needs of that community's population. Nonprofit navigator groups typically have expertise in one or more communities such as veterans or populations with limited English proficiency and serve as a trusted resource for many community members. These are critically important competencies that non-community-based groups lack. Removing these requirements for Navigator entities would limit the ability of consumers to get unbiased, high-quality assistance from organizations they trust. Additionally, the Affordable Care Act requires that consumers are able to enroll in coverage on the phone, online, via a paper application and in person. Removing the requirement that a Navigator entity have a physical presence in their service area will lead to entities that are unfamiliar with the community and consumer needs as well as create insurmountable barriers for enrollment of consumers who lack access to a phone or the internet or those consumers requiring extensive follow-up assistance. SOPHE urges CMS to not make any changes that would enable entities to provide only remote assistance, rather than in-person assistance, as required by the Affordable Care Act. In summary, SOPHE asks that CMS maintain requirements for Exchanges to have at least two Navigator entities, one of which must be a community-based and consumer focused nonprofit, and require that Navigators maintain a physical presence in the Exchange service area. These regulations were put in place to ensure that consumers are able to get the best assistance available and these provisions are necessary to ensure that the nation's most vulnerable populations get enrolled.

Thank you for consideration of our comments. The Affordable Care Act and its associated markets have provided quality, affordable health care to millions of Americans since their inception in 2014. SOPHE looks forward to continuing to work with CMS on ensuring that the

markets remain viable for middle class Americans to receive the health care they need. Please contact Dr. Cicily Hampton at (hampton@sophe.org) or 202-408-9804 with any additional questions.

Sincerely,

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

Elaine Auld, MPH, MCHES
Chief Executive Officer