



December 11, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: Comments on Draft *2019 Letter to Issuers* in the Federally-facilitated Marketplaces

Dear Administrator Verma:

The **I Am Essential** Coalition of patient and community organizations, representing millions of patients and their families, appreciate the opportunity to submit comments on the [2019 Draft Letter to Issuers in the Federally-facilitated Marketplaces](#) (FFMs). These comments build on our recently submitted [response to the 2019 Notice of Benefit and Payment Parameters](#), and address more specifically the changes in guidance to issuers for plan year 2019. In those comments, signed by 138 patient groups, we voiced our strong opposition to proposed changes on how states can select their essential health benefits. We believe that in HHS' effort to increase state flexibility, patient care will be diminished and beneficiary out of pocket costs will be increased. Therefore, we urged HHS to maintain the current process for states to select their essential health benefits.

We commend the Centers for Medicare and Medicaid Services (CMS) for continuing to provide issuers with the operational and technical guardrails that protect patients in such ways as non-discrimination standards in qualified health plans (QHPs) and essential health benefit (EHB) design, including prescription drug coverage. We also support the approach to reviewing prescription drug offerings and clinical appropriateness. However, we are concerned that those standards may not be enforced as intended which could impact the health and wellbeing of beneficiaries, especially those with serious and chronic conditions that depend on comprehensive coverage and robust access to treatment and care.

CMS' Commitment to Patient Protections

I Am Essential applauds CMS' commitment to non-discrimination standards as outlined in the *Letter to Issuers for 2017*, and referenced in Chapter 2: Section 10, along with the Prescription Medication requirements in Section 11. These are critical for beneficiaries to access the full range of benefits they need. We again urge CMS to perform the "adverse tiering review" to evaluate QHP coverage of drugs to treat commonly diagnosed, chronic, and high-cost conditions as there is concern issuers may employ this tactic, discriminating against beneficiaries that utilize certain medications and treatments.

As we wrote in the past to you, continuation of these patient protections is critical so that qualified health plans meet the needs of beneficiaries, particularly those with serious and chronic conditions. We thank HHS for recognizing their importance by maintaining them in the *2019 Proposed NBPP* and the *Letter to Issuers for 2019*.

However, as we have also previously stated, patient protections are meaningless without proper enforcement. Despite the law or regulation, some insurers still design plans that are discriminatory and limit patient access. Beneficiaries continue to encounter plans that lack meaningful formulary coverage for prescription medications, engage in adverse tiering, have high cost-sharing and burdensome utilization management requirements such as extensive and/or unwarranted prior authorization and step therapy requirements. Beneficiaries also still face midyear formulary changes, and can have their medications switched for non-medical reasons. Current regulations and guidelines must be enforced.

We are concerned that in an effort to provide greater state flexibility we will erode beneficiaries' access to quality healthcare as some states will not enforce these important patient protections. 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 they have no interest in or a limited capacity to implement plan requirements included in the ACA, including the important patient protections.

Therefore, we encourage HHS to fully enforce the patient protections contained in the law and in regulation, and ensure that if oversight and enforcement responsibilities are assumed by the states, they have the authority and resources necessary to fully address patients' protections, particularly non-discrimination in plan benefit design.

Deference to States for Qualified Health Plan Certification Review

I Am Essential is concerned that deferring to states to perform the review of QHPs, "exercising reasonable flexibility" in the application of CMS' QHP certification standards could allow for relaxed compliance without any federal oversight as covered in Chapter 2: Sections 2, 3, and 4. We are concerned that in an effort to give states more autonomy in their oversight of the QHP review process, some states will not enforce the certification standards, thereby eroding beneficiaries' access to quality healthcare. Furthermore, some states have expressed a lack of interest to implement plan requirements in the Affordable Care Act (ACA), including the important patient protections. Working

together with States to review plan certification, accreditation, service area, and network adequacy can ensure standards are met, without placing the burden fully on either the state or the federal partner.

Waive Standardized Plan Options and Meaningful Difference Standards

Additionally, as noted in our comments on the *2019 Proposed NBPP*, we are disappointed that CMS has proposed to remove both the standardized plan options and the meaningful different requirement as part of the certification process. In Chapter 1: Section 7, and Chapter 2: Section 12 of the *Letter to Issuers* reiterates CMS' intent to forgo these measures and we urge the Department to reconsider. We believe 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, and exempting drugs in most metal levels from the deductible. Standardized plans can help reduce the cost-sharing burden for beneficiaries and allow them to actually utilize their health insurance.

We also oppose the proposal to abandon the "meaningful difference standard." Shopping and selecting a plan that best meets a beneficiary'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. We disagree with the Department's assertion that the current "meaningful difference standard" limits innovation and believe the existence of such standards encourages greater innovation and differences among plans.

Weakening Provider Networks by reducing Essential Community Provider Requirements

We are opposed to the proposal to weaken the means by which an issuer can meet the regulatory standard of Essential Community Providers (ECP) by reducing the percentage to twenty percent stated in Chapter 2: Section 4. Individuals that require specialized care for their chronic conditions rely on networks that include ECPs. This requirement has not proven to be a burden to issuers, however eliminating it would have detrimental effects on the beneficiaries of those plans.

Thank you for your consideration. Should you have any questions, please contact: Carl Schmid, Deputy Executive Director, The AIDS Institute, cschmid@theaidsinstitute.org; Beatriz Duque Long, Senior Director, Government Relations, Epilepsy Foundation, bduquelong@efa.org; Andrew Sperling, Director of Federal Legislative Advocacy, National Alliance on Mental Illness, asperling@nami.org.

Sincerely,

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