AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Mail Stop 314G
Washington, DC 20201

Re: Patient Protection and Affordable Care Act: U.S. Department of Health and Human Services Notice of Benefit and Payment Parameters for 2019; Proposed Rule

Dear Administrator Verma:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed Notice of Benefit and Payment Parameters for 2019 ("payment notice"). While the AMA appreciates that the Administration's overall goal is to give states more flexibility and reduce burdens on stakeholders in order to stabilize the markets and improve health care affordability, we believe that some of the proposals in the payment notice could undermine existing consumer protections under the Affordable Care Act (ACA) and harm patients. Accordingly, the AMA's comments focus on several areas about which we have concerns, including changes to the ACA's Essential Health Benefits standard, standardized plan options, network adequacy standard, essential community providers, and medical loss ratio rules.

Proposed Changes to Essential Health Benefits

The ACA requires health insurance plans in the individual and small group markets to cover 10 general categories of essential health benefits (EHB), including emergency services, hospitalization, prescription drugs, maternity care, and care for mental health and substance abuse disorders. The EHBs must be covered to the extent that they would be under a typical employer plan, but the scope of coverage is determined by states which can choose a benchmark plan for the coverage. Currently, states must choose benchmarks based on plans sold within their own state. The payment notice, however, would lift this restriction and allow states to replace their benchmark plan with all or part of another state's benchmark or establish a new benchmark plan for EHB as long as it is equal to the scope of benefits provided under a "typical employer plan" in the small group or large market with more than 5,000 enrollees. In addition, the payment notice would bar states from making their EHBs any more generous than they are currently. Also, in implementing the EHB, the payment notice proposes that insurers could substitute benefits across categories, meaning that they could trade off one type of service for another.

The AMA is very concerned that these aforementioned proposed changes could lead to skimpier health care plan benefits in the individual and small group insurance markets and result in higher out-of-pocket

costs for patients. We urge CMS not to adopt these changes. States basically would have carte blanche to weaken the EHB package, and could potentially choose, for example, an employer plan that excludes coverage for inpatient mental health services, coverage for HIV or AIDS, or transplants; or a state could select one state's hospitalization coverage and another state's maternity coverage. Such plans would be considered "typical" under the proposed payment notice's new definition of typical, i.e., any large or small group health insurance, or a self-insured group health plan, with at least 5,000 covered lives, offered in any state. Under the current standard, the EHB benchmark is required to be equal in scope to the most popular employer plans in a state. Under the proposed definition, there would be no requirement for the state to assess how common the plan would be or even whether it exists in the state that considers using it as its benchmark. These changes could lead to a state choosing a benchmark benefit that includes the least comprehensive coverage in any state across all 10 benefit categories, which could leave patients with a narrow set of benefits that does not provide the appropriate access to care that patients with pre-existing medical conditions or managing complex conditions need to maintain their health. As a result, anyone who faces a health issue could end up having to pay much more out of pocket. CMS itself acknowledges that, depending on the selection made by the state in which the consumer lives, consumers with less comprehensive plans may no longer have coverage for certain services.

With respect to letting states define their own EHB package, if a state can find a single employer plan anywhere in the country covering 5,000 people that offers a very narrow benefit (e.g., a plan that covers only preventive services and not emergency services, most inpatient hospital services, substance abuse treatment, or most prescription medications), the proposed payment notice would allow the state to define a minimal EHB package that offers a limited benefit for each EHB category and meet the EHB standard proposed by CMS. As another example, some employer plans could sharply limit the number of hospital days or physician visits available to patients each year, or some plans could cover only generic medications or provide limited coverage of brand-name drugs. If a state is allowed to select low-value employer plans as the basis for developing a new EHB benchmark, this could significantly reduce the overall value of the ACA benefit package. These proposals for choosing benchmark plans and categories could discourage states from offering comprehensive coverage because they would be responsible for defraying the costs beyond a minimal benefit threshold. The AMA is concerned that this could lead to a race to the bottom where health insurers would be reluctant to offer more generous coverage because they would not want to attract all of the sicker enrollees. While we agree that the exchanges need to offer patients with choices to spur competition, we believe that such a policy could lead to less choice and higher costs for patients.

As mentioned above, CMS is proposing that individual and small group plans be allowed to substitute benefits—with the exception of prescription drugs—between EHB categories if the substituted benefit is actuarially equivalent to the benefit being replaced. Plans that substitute benefits would still have to meet other requirements, such as not having the benefit package be unduly weighted toward a particular benefit. This proposal would take away a state's ability to define an EHB package and will make it harder for consumers to compare plans. We urge CMS not to finalize this proposal. In addition, to the extent that any substitution of benefits is allowed, it is critical that CMS continue to not allow plans to substitute prescription drug benefits, either within the drug benefit or between the drug benefit and other benefits. Each prescription drug often treats just a small subset of the population and so patients need access to a broad formulary. The benefits of one type of drug cannot be traded for another and the benefits of a broad formulary cannot and should not be traded for other types of medical care.

We are also concerned that the proposed changes could negatively affect health insurance coverage for employees of large and self-insured employers because key ACA cost protections, i.e., the annual cap on out-of-pocket costs and the ban on annual and lifetime limits, are linked to the definition of EHB. For example, a benefit within a required benefit category that is no longer considered to be an essential benefit would no longer be protected under the out-of-pocket cost cap or the annual and lifetime limits.

At the AMA's recent Interim Meeting, our policymaking House of Delegates voted to oppose any weakening of the ACA's EHBs. At the heart of this policy is the belief that patients need to have meaningful coverage that protects them against catastrophic expenses. Under current law, the requirement that all qualified health plans offer at least the EHBs in the EHB package has helped ensure that individuals have access to meaningful coverage. Using the current benchmark approach to EHBs, while requiring 10 categories of EHBs, strikes a balance between offering meaningful coverage and maintaining patient choice in health plans and their respective benefits packages. We believe that the payment notice moves in the wrong direction with respect to protecting the EHB requirements in the ACA, and urge CMS to withdraw its proposed changes to EHBs.

Standardized Plans and Meaningful Difference Standard

CMS proposes to stop offering standardized plan options, also known as Simple Choice plans. These plans have standardized cost-sharing and benefit design elements, and have been offered on the federally facilitated marketplace since the 2017 plan year. These plans helped simplify options for consumers and also offered cheaper options for individuals with high deductibles, since the plans covered services such as primary care visits and generic drugs before the deductible. The AMA supported the standardized plan options in our previous comments to CMS on the proposed payment notices for the 2017 and 2018 plan years, and we continue to believe that providing the Simple Choice plans helps consumers navigate the wide range of health options available on the marketplace. We urge CMS to reconsider its decision to abandon the standardized plan options.

Likewise, CMS proposes to eliminate the "meaningful difference" standard for qualified health plans offered through the federally facilitated marketplace. Under current rules, qualified health plans must be "meaningfully different" from other plans offered by the same insurer within a service area and metal level tier. This requirement was adopted to help facilitate consumer comparison and choice, and we urge CMS to reconsider its decision to eliminate it.

Network Adequacy and Essential Community Providers

The AMA is concerned that the proposed payment notice would undo progress made toward ensuring adequacy of provider networks and impede access to care for patients. In efforts to reduce premiums, insurers are increasingly narrowing their provider networks. As a result, strong network adequacy requirements and regulations are more important than ever. Unfortunately, this proposal further unravels many of the positive changes CMS has taken in the past to address timely patient access to the providers they need.

Specifically, the proposed payment rule would extend new guidelines on network adequacy and essential community providers finalized in the 2018 Market Stabilization rule. The AMA opposed those changes then and opposes any extension of the changes now.

While many states have network adequacy requirements in place, most are insufficient to address the needs of patients in this narrow network environment. This insufficiency has lead regulators, including the National Association of Insurance Commissioners (NAIC), legislators, patient groups, provider organizations, and many other stakeholders to push for changes to network adequacy requirements in the states. While some states have been successful in making meaningful changes to address narrower networks (e.g., Maryland, Illinois, Hawaii, Connecticut), most states, unfortunately, have not acted.

As a much needed stopgap, CMS had established a minimum federal standard for network adequacy that included quantitative, measurable standards. Unfortunately, the 2018 Market Stabilization rule temporarily undid those requirements, and this rule proposes to solidify those changes. The current proposal would remove that floor "for 2019 and beyond." The AMA believes that state regulators should have flexibility to regulate their provider networks, but we also believe there is a critical need for a minimum federal network adequacy standard that includes quantifiable standards, especially in light of inaction in many states to update network adequacy requirements. We urge CMS to reinstate a federal minimum standard and to move forward in further developing it.

If states do not regulate network adequacy, the proposed payment notice allows certification through accreditation. The AMA continues to oppose the idea that accreditation could serve as a substitute for network adequacy regulation and is deeply concerned about the impact that this alternative would have on patient access to care. Accreditation standards are not available to the public, accreditors do not have regulatory authority over plans, and these organizations are not in a position to monitor network adequacy via consumer complaints or other such commonly used means. The NAIC itself rejected the notion that accreditation can serve as a substitute to regulation in their Health Benefit Plan Network Access and Adequacy Model Act. We strongly urge CMS to recognize accreditation as an important complement to active regulation of provider networks, but not as an alternative.

We continue to oppose relying upon, as a third alternative to network adequacy certification, a plan's self-attestation to meeting the requirements laid out in the NAIC's Health Benefit Plan Network Access and Adequacy Model Act. While the AMA views many of the network adequacy proposals in the NAIC's model act as good starting points to build strong network adequacy legislation, the model is meant to be just that – a starting point for legislation. It is a document filled with drafting notes and options for state legislators to consider and on which to reach consensus, and was not drafted as a polished regulatory tool. We believe there are many provisions of the NAIC Model Act that could inform excellent network adequacy regulation, specifically those that prevent reliance on accreditation by regulators and encourage active regulation of provider networks using quantitative standards. We encourage the adoption of these specific proposals by state regulators and CMS.

Additionally, as we urge you to re-implement a federal regulatory floor for network adequacy for federal facilitated exchanges, we also urge you to require that state-based exchanges that use HealthCare.gov (SBE-FPs) abide by that regulatory floor if state regulations are not as strict, as was finalized in the 2017 Payment Notice. Without such requirements, we fear that patients will continue to encounter problems with timely access to providers.

Finally, the AMA is very concerned about the patient impact of extending the reduction of the minimum essential community provider (ECP) requirement from 30 percent to 20 percent. ECPs include those that care for individuals in low-income and/or medically underserved communities, often the same patients that are negatively impacted by inadequate networks. The current ECP requirement is an important

protection from discriminatory network designs and network structures that leave out providers that care for these underserved patients. On its own, this proposal to reduce the ECP requirement would have a very negative impact on vulnerable populations, and combined with the network adequacy proposals could be devastating for many patients.

Medical Loss Ratio (MLR) Rules

As currently implemented, the MLR standard provides an improved level of transparency in the health insurance market for all parties as compared to the level that existed prior to its implementation. In addition, the current MLR standard ensures patients that their premiums are spent on actual medical care rather than administrative costs. If an insurer does not meet the 80/85 threshold, the insurer must provide a rebate to its enrollees. This threshold is what balances the premiums that insurers receive versus the profits that insurers earn. That is the appropriate balance previously negotiated by all stakeholders through the NAIC – and the appropriate balance that the AMA strongly believes must continue to be in force.

Most insurers have implemented efficiencies that allow them to easily meet the MLR standards, indicating that the requirement is working largely as intended. In fact, while $1.1 billion in rebates were paid out to patients in 2011, only $397 million were paid out in 2016. In other words, insurer administrative costs remain higher than what they are paying out in patients' medical costs. Despite this, this proposed rule is suggesting significant changes to weaken the MLR requirements on insurers, and the AMA is very concerned that these changes will reduce the value of coverage to patients not to mention the actual medical care covered by insurers.

The AMA opposes the proposed change regarding employment taxes and urges CMS to continue the existing requirements that employment taxes not be excluded in the premium in the MLR and rebate calculations. These taxes should be considered employments costs, rather than excludable taxes under the ACA.

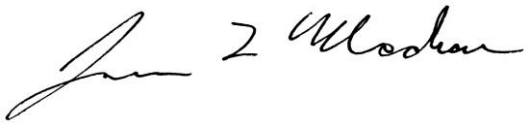
It is unclear to the AMA why there is a need for a floor, or automatic deduction for quality expenses, based on earned premiums. Several insurers currently report specific quality improvement expenses, so it appears that there is incentive to do such reporting at an individual level. Therefore, it is unclear to the AMA why there would be a need to establish a minimum deduction at this point. Moreover, the proposed 0.8 percent of earned premiums is on the higher end of what most insurers are reporting for quality improvement expenses currently, thereby allowing many insurers to claim more quality expenses than appropriate. The AMA urges CMS to reject this proposal in the final rule.

The AMA opposes relaxing the requirements on states to justify MLR reduction requests. While we support state flexibility and continue to push for policies to improve market stability in the states, we cannot support policies that would result in decreased coverage, care or value for patients. CMS estimates that 22 states would initially request MLR reductions to 70-75 percent with the new criteria. While CMS may view this as a market stability proposal, unfortunately, the AMA sees this as a proposal to decrease the value of patient premiums. Rather than moving forward with proposals that could result in decreased levels of coverage, we urge the Administration to stabilize the individual markets through cost-sharing reduction payments, strong outreach and enrollment efforts, enforcement of the individual mandate, and other strategies that do not adversely affect patients. Use of these important tools will go

much further in securing insurers' commitment to the individual market places, while ensuring that patients have access to the care they need and are receiving value for their premiums paid.

Thank you again for the opportunity to submit comments. If you have any questions, please feel free to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or (202) 789-7409.

Sincerely,



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