

November 27, 2017

The Honorable Eric Hargan
Acting Secretary
Department of Health & Human Services
200 Independence Avenue
Washington, DC 20201

Submitted electronically

RE: Patient Protection and Affordable Care Act – HHS Notice of Benefit and Payment Parameters for 2019 Proposed Rule, CMS-9930-P

Dear Acting Secretary Hargan:

On behalf of the 54 million adults and nearly 300,000 children in the United States with doctor-diagnosed arthritis, the Arthritis Foundation welcomes the opportunity to offer comments on the proposed rule regarding the 2019 Notice of Benefit and Payment Parameters. Arthritis is a complex chronic disease that can be difficult to treat, and people who suffer from the disease require regular, ongoing care. The Arthritis Foundation exists to boldly pursue a cure for America's number one cause of disability, while championing the fight against arthritis with life-changing resources, science, advocacy, and community connections. For many in the arthritis community, access to affordable, adequate health care can mean the difference between a life of chronic pain and disability and a life of wellness and full mobility.

While we are pleased that HHS continues to focus on supporting the adoption of people-centered, evidence-based care, we are particularly concerned that the proposed changes regarding how states can select essential health benefits (EHBs) will jeopardize patient protections under current law and increase out-of-pocket costs. The downstream effects of a potentially narrowed construction of an essential health benefits benchmark would harm appropriate care and treatment for patients with arthritis. Below please find our comments on the proposed rule.

Essential Health Benefits

HHS proposes sweeping changes to essential health benefits (EHBs) that are intended to increase flexibility to states in defining EHBs. In addition to allowing states to maintain their current 2017 EHB benchmark plan, the proposed rule outlines three other options that states may select. The Arthritis Foundation is deeply concerned

that the proposed flexibility may mean these benchmark plans would no longer be representative of plans offered across each state, resulting in the proliferation of plans consisting of limited benefits. For instance, permitting a state to replace one or more EHB categories in its benchmark plan with categories from another state could result in a benchmark plan that includes all the least comprehensive of the ten EHBs, including the prescription drug benefit. We appreciate that the proposal notes if a plan covers drugs beyond the number of drugs covered by the benchmark, all of these drugs are considered EHBs and must count toward the annual limitation on cost-sharing.

HHS has also proposed to let states select a set of benefits that would become its EHB benchmark using a different process. Under the proposed definition of a typical employer plan, states could select an employer plan from anywhere around the country that offers the least comprehensive benefits available, and may not even cover all ten of the EHBs. In this scenario, it is not hard to envision a marketplace that lacks sufficient choice or competition – cornerstones of a well-functioning health care marketplace.

Importantly, for many people with arthritis, affordability of life changing treatments is interchangeable with access to these treatments. People with arthritis are increasingly subjected to 40-50 percent cost-sharing requirements for specialty medications such as biologics; there are no guarantees that the drugs they need will be on their health plan's formulary. Given the complexities associated with managing arthritis, this aspect of the proposed rule has the very real potential to affect how arthritis patients access appropriate care and treatment for their disease. Further, these proposals would serve to discourage states from offering comprehensive coverage as they would be required to defray the costs of any benefits above a minimum level of benefits. We strongly urge HHS to avoid implementation of these proposed modifications in the final rule and instead maintain the current process states utilize to select their EHBs.

National Benchmark Standard for Essential Health Benefits

For future plan years, HHS has proposed to develop a “federal default definition of essential health benefits” that is intended to better align risk and balance costs with regard to the scope of benefits. As an example, HHS indicates that this approach could include the establishment of a national benchmark plan standard for prescription drugs. Without additional clarity on this proposed policy, we are concerned that the requirement for states to defray costs of formulary options offered above the proposed national benchmark would result in narrowed formularies, translating into higher out-of-pocket costs for people with arthritis. We are

concerned that a national prescription drug benchmark would open the door to the removal of annual caps and the application of lifetime limits to those medicines excluded from the benchmark. Similarly, a national formulary could place new, innovative therapies such as biologics out of reach for patients, limit access, and undermine the ability of providers to treat patients based on their unique health care needs.

Standardized Plan Options

HHS proposes to not “specify standardized options or to provide differential display of standardized options” for 2019. We are disappointed that HHS has chosen to reverse course and abandon the standardized plan options. The Arthritis Foundation supports the concept of standardized plans as way to offer consumers an easier way to compare plans across issuers.

Overall, the proliferation of specialty tiers coupled with rising co-insurance are a great concern for the Arthritis Foundation. For instance, Avalere data shows that consumer costs for specialty drugs increased from 2016 to 2017; on average, co-insurance for specialty drugs increased from 34 percent to 37 percent for silver plans. In addition, about 50 percent of silver plans charged over 30 percent co-insurance for specialty drugs, representing a double digit increase over 2016.¹ Furthermore, a *Health Affairs* study found that enrollees switching from employer plans to exchange silver level plans faced out-of-pocket costs that were considerably higher: for enrollees with arthritis, the study authors predicted a 95 percent increase in annual out-of-pocket spending, an amount that increases for enrollees with multiple chronic conditions.²

Risk Adjustment

As we have noted in prior comments, we support the incorporation of prescription drug data in the risk adjustment methodology. Many people with chronic diseases such as arthritis rely on medications to live healthy, productive lives. We agree that drug utilization data can be useful in representing missing diagnoses, indicating the severity of an individual's condition, and providing more timely and accessible information than medical claims. We are pleased that HHS has maintained the arthritis-related prescription drug utilization factors (RXC) as part of its proposed drug-diagnosis pairs for 2019. We encourage HHS to consider the fact that nearly half of adults with arthritis also have at least one comorbid condition such as obesity,

¹ Avalere Planscape. (2016). <http://avalere.com/expertise/life-sciences/insights/consumer-costs-continue-to-increase-in-2017-exchanges>. Retrieved November 17, 2017.

² Thorpe, Kenneth; Allen, Lindsay; Joski, Peter. “Out-Of-Pocket Prescription Costs Under a Typical Silver Plan Are Twice as High As They Are In The Average Employer Plan.” *Health Affairs*. Vol 34, No 10 (2015): 1695-1703.

diabetes, or heart disease, and the number of drug classes should be sufficiently robust to adequately capture the patient's full health profile.³

Additionally, despite the Affordable Care Act's promise to end discrimination based on pre-existing conditions, many health insurance plans continue to engage in practices that discourage enrollment of patients with serious and chronic conditions. We believe that compensating payers through mechanisms like risk adjustment for their enrollees who need and use higher-cost prescriptions and services will reduce incentives for issuers to engage in adverse selection for the patients who need health insurance the most.

Network Adequacy

HHS proposes for 2019 and future plan years to rely on state reviews in states with the authority to enforce standards that are at least equal to the "reasonable access standard." For states that do not have such authority, HHS proposes to rely on an issuer's accreditation from one of three accrediting entities. For unaccredited issuers, HHS further proposes they must submit an access plan that is consistent with the National Association of Insurance Commissioner's (NAIC) Model Act. Network adequacy is critically important to people with arthritis, who require regular, ongoing access to both primary and specialty care. We believe the Model Act moves the network adequacy accreditation process in the right direction, but we urge HHS to provide states with the resources needed to adequately ensure plans are in compliance with network adequacy standards. To date, no states have adopted the NAIC Model Act, and there is a need for continued state and federal oversight. Further, we caution against relying solely on issuer accreditation in the absence of state accreditation, and believe issuer accreditation is not a substitute for federal oversight. Further, although we reiterate our support for many aspects of the Model Act, we believe more quantitative standards are necessary to measure network adequacy, such as wait times for scheduling appointments and whether providers are accepting new patients.⁴

Plan Innovation

HHS seeks comments on how to encourage value-based insurance design in the marketplace, inclusive of promoting the availability of health savings account-eligible high deductible health plans (HSA-HDHPs). We recognize that the use of HSA-HDHPs is expanding, and note that a number of policies have been proposed by

³ Centers for Disease Control and Prevention. (2017). "Comorbidities." https://www.cdc.gov/arthritis/data_statistics/comorbidities.htm. Retrieved November 17, 2017.

⁴ See <http://www.arthritis.org/Documents/Sections/Advocate/Regulatory-Letters/HHS-Market-Stabilization-Rule.pdf>

Congress this year to increase flexibility and remove barriers to their use. In the marketplaces, for instance, nearly 90 percent of enrollees are in health plans with deductibles that would qualify the plan as an HDHP as defined by the Internal Revenue Service.⁵ Exchange enrollees that are low-income, older, or have a chronic illness like arthritis are also disproportionately more likely to meet their deductibles and hit maximum annual out-of-pocket limits within the first months of the plan year.

To learn more about arthritis patients' interactions with HSAs, the Arthritis Foundation conducted a focus group earlier this year. While participants noted that they find value in HSAs, they indicated that policies should be designed to work for people with chronic disease in the following ways:

- Front-loading HSA dollars and matching the upper limit to the maximum out-of-pocket spend to ensure they work for people with high medical costs;
- Broadening the list of qualified medical expenses in order to account for the fact that people with arthritis depend on a large range of prescription drugs, health care services, and over-the-counter products. In particular, consideration should be made for transportation to appointments, as regular contact to multiple providers is a regular part of life for people with arthritis;
- Including non-opioid pain management services like massage and yoga, not traditionally thought of as medical, as qualified expenses;
- Simplifying administrative requirements to more easily approve qualified medical expenses and make HSA dollars more easily accessible; and
- Making available navigators or other personal support representatives who are trained to specifically help patients understand how to use HSAs. The elimination of navigator resources earlier this year, as well as the proposed removal of other requirements in this rule, will hinder the ability of HHS to promote availability of these arrangements.

Our experiences with focus groups and surveys have reinforced to us the value of patients' active involvement in their own care, in the health care system in which they participate, and in research that pertains to them. We welcome an opportunity to serve as a resource to HHS in collecting data and feedback on these issues to ensure plan innovations and other administration health care policies align with the needs of arthritis patients.

⁵ Health Affairs. (2016). *Health Policy Brief: High-Deductible Health Plans*.
http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_152.pdf

Navigators

The Arthritis Foundation is very concerned by proposals that would further scale back the navigator program; earlier this fall, we expressed concern regarding the termination of two contracts for outreach and engagement programs designed to sign up individuals for health care coverage. The proposed rule would remove the requirement that each exchange must have at least two navigators and that one must be a community non-profit; and removes the requirement that a navigator needs to maintain a physical presence in the state. Taken together, we question whether navigators can adequately perform statutory responsibilities under the law (e.g., providing information about EHBs, qualified health plans, distributing culturally and linguistically appropriate information) with these proposed changes. Arthritis is the leading cause of disability in the United States, which presents a unique set of access challenges for many people who suffer from the disease. In addition, certain populations – including African Americans and Hispanics – report worse impacts and daily limitations from arthritis. Weakening the physical presence requirement will make it even more challenging to reach these populations.

Again, thank you for the opportunity to comment on the proposed rule regarding the 2019 Notice of Benefit and Payment Parameters. We urge HHS to continue to enforce important patient protections in current law, and avoid proposals that have the potential to erode these protections. Please contact Vincent Pacileo, Director of Federal Affairs, at vpacileo@arthritis.org, with questions or for more information.

Sincerely,



Anna Hyde
Vice President, Advocacy and Access
Arthritis Foundation