AMERICAN LUNG ASSOCIATION.

Harold P. Wimmer
National President and CEO

November 27, 2017

The Honorable Eric D. Hargan
Acting Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW

Dear Acting Secretary Hargan:

The American Lung Association appreciates the opportunity to comment on the HHS Notice of Benefit and Payment Parameters for 2019.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD. The Lung Association has significant expertise in lung disease and the care required to manage those diseases. In 2015, Lung Association staff co-authored "Standards for Asthma Self-Management Education" published in the Annals of Allergy and Clinical Immunology, and serves as the standard of practice.

Additionally, the Lung Association's Helpline has served as an enrollment assistor helping patients enroll in the marketplace. The Lung Association has also partnered with the Self-Made Health Network to educate navigators about tobacco surcharges and tobacco cessation.

The American Lung Association is committed to ensuring all patients are treated with guidelines-based care. Since 2008, the organization has tracked tobacco cessation coverage in state Medicaid programs and since 2016 the Lung Association has collected state Medicaid programs' coverage of guidelines-based asthma care. It is imperative that patients getting healthcare through the exchanges also have access to guidelines-based care. While state flexibility is important, the Lung Association urges the Department of Health and Human Services to make sure plans sold on the exchanges offer treatments, so providers can care for their patients according to the guidelines.

Advocacy Office:
1331 Pennsylvania Avenue NW, Suite 1425 North
Washington, DC 20004-1710
Ph: 202-785-3355 F: 202-452-1805

Corporate Office:
55 West Wacker Drive, Suite 1150 | Chicago, IL 60601
Ph: 312-801-7630 F: 202-452-1805 info@Lung.org

In March of 2017 the Lung Association committed to a set of healthcare principles (see Appendix A). The principles state that any changes to the healthcare system must achieve healthcare that is affordable, accessible and adequate for patients. Unfortunately, some of the policy proposals detailed in the proposed Notice of Benefit and Payment Parameters for 2019 (NBPP) do not meet the standards that patients need. The American Lung Association requests that the Department modify the proposals in the final NBPP rule to ensure all Americans have quality and affordable healthcare.

Changes to the Essential Health Benefits (EHB)

The Lung Association is concerned the changes proposed in Section 156 of the rule will make healthcare coverage less robust for patients in the exchanges resulting in less adequate care. Since the lifetime and annual limits only apply to the EHB, if the definition of EHB changes with a decrease in coverage, these essential protections are lost. Many lung diseases, such as lung cancer, require innovative and expensive therapies, such as targeted immunotherapies, to survive. It is vital for our patients that their treatments are not subject lifetime or annual limits.

The proposal in section 156.111 would allow states to change their benchmark plans in one of three ways. While states would still be required to cover all 10 EHB categories, the Lung Association believes this could lead to a reduction of benefits offered as part of the EHB.

The first option states have is to change their benchmark plan and choose another state's benchmark plan. The Lung Association is concerned that this would encourage states to choose a plan with less generous benefits. For example, just less than half of 2017 benchmark plans cover bariatric surgery.[1] If this policy was adopted, states may choose a state benchmark with less generous benefits, reducing coverage for patients.

The second option would allow a state to select EHB categories from other states' benchmark plans. The Lung Association opposes this option. If a state were to pick and choose the 10 EHB categories from multiple other states, the Frankenstein-like state benchmark plan would not resemble a typical employer plan. This is not only contrary to the law, but also harmful to patients. There are no protections or guardrails that would maintain robust coverage that patients have under the current approach. The Lung Association urges the Department not to adopt this proposal in the final rule.

The third option would allow states to create their own benchmark plan as long as it resembles a typical employer plan. The Lung Association believes this approach is misguided and will result in harm to patients. The proposed rule loosely defines a "typical employer plan," but does not preclude high deductible or grandfathered plans from the definition. Patients in states that choose

[1] "Essential Health Benefits: Benchmark Plan Comparison 2017 and Later," Cigna, January 2017, available at https://www.cigna.com/assets/docs/about-cigna/informed-on-reform/top-11-ehb-by-state-2017.pdf.

less generous benchmark plans could face higher out-of-pocket costs, fewer protections in terms of annual and lifetime limits and less coverage in general.

In the past few years, states have increasingly reduced coverage in their state Medicaid programs, under the guise of controlling costs. For example, Massachusetts recently submitted an 1115 waiver that would allow for the creation of a closed formulary with a floor of one drug per class, which would severely limit the robustness of the coverage provided. The Lung Association believes this pattern of reducing benefits would continue with the benchmark plans. The Department admits that "*consumers who have specific health needs*" may be adversely impacted by this proposal. "*Depending on the selections made by the state in which the consumer lives, consumers with less comprehensive plans may no longer have coverage for certain services.*"[2] Lung disease patients have specific health needs and their lives depend on their treatments. The Lung Association urges the Department not to adopt this proposal in the final rule.

Shifting Actuarial Value

In section 156.115, the Department proposes to allow plans to adjust the actuarial value (AV) between nine of the ten EHB categories. The proposal excludes the prescription drug category. By allowing plans to adjust the AV between categories, the Lung Association fears plans may shift the generosity of the benefit to less used categories. This provision could be used to encourage sicker patients to not choose the health plan due to the lack of benefits the plan offers. For example, a plan could weaken coverage categories for consumers with high medical needs and costs in an attempt to only attract healthy and inexpensive consumers. Lung disease patients could see fewer plans covering the treatment they need, decreasing healthcare coverage options.

There are also broader market implications by allowing plans to adjust the AV value and create an adverse selection in the marketplace, including weakening the stability of the marketplace. The Lung Association requests the Department to remove this section from the final rule.

Premium Review

The Lung Association is concerned about the proposed changes in *Part 154 – Health Insurance Issuer Rate Increases; Disclosure and Review Requirements*. The proposal to increase the threshold triggering a rate review from a 10 percent increase to a 15 percent increase is deeply troubling.

Many lung disease patients, including those with asthma, COPD and lung cancer require regular treatments to manage complex medical conditions. The first barrier to accessing needed treatment is having health insurance. Increasing premiums can be devastating for these patients and lead to some patients going without health coverage. Without affordable, quality healthcare, patients with lung disease will not have the treatment they need, resulting in poor health outcomes or death.

[2] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 82 Fed. Reg. 51313 (Nov 2, 2017). Available at: https://www.gpo.gov/fdsys/pkg/FR-2017-11-02/pdf/2017-23599.pdf

From 2017 to 2018, the average benchmark plan premium increased by 37 percent. Increasing premiums, even with Advanced Premium Tax Credits (APTC), pose a burden for patients to purchase healthcare coverage. For patients with lung disease, having health insurance allows access to treatment to manage their disease. For example, a patient with asthma needs maintenance medication to prevent asthma exacerbations. For patients with lung cancer, the ability to afford health insurance is literally a matter of life and death. Healthcare needs to be affordable to patients, including patients who need a robust benefit.

The rate review process is the only consumer protection from unnecessarily burdensome rate increases. For lung disease patients who depend on medical treatment to breathe, it is important that premiums remain affordable. The Lung Association urges the Department to keep the threshold at a 10 percent increase. Increases above the 10 percent threshold are burdensome to patients and the Department has a responsibility to ensure the increases are legitimate and protect patients from arbitrary rate increases.

Enrollment Navigators

Section 155.210 and Section 155.215 reduce the number of state navigators from two per exchange to one per exchange. Additionally, these sections would remove the requirement that one of the two navigators be a community and consumer focused non-profit. The section also removes the requirement that at least one of the navigators have a physical presence. The Lung Association believes this is misguided and will harm patients and urges the Department not to include this provision in the final rule.

The Lung Association has collaborated with local enrollment navigators through a partnership with the Self-Made Health Network to help educate navigators about the tobacco surcharge and tobacco cessation resources. Through this partnership, the Lung Association has worked closely with the navigators and has seen the benefits of having community-based organizations engaged in face-to-face interactions with consumers. Navigators serve as liaisons to their community and have the ability to address and help consumers overcome modifiable barriers to sign up for healthcare.

Navigators play an important role in helping consumers obtain consistent access to comprehensive health insurance through publicly-funded programs such as Medicaid but also in helping them to remain consistently insured. Navigation services are ideal to address many of the health disparities associated with diversity, literacy and culture because they foster a sense of trust and empowerment within the communities they serve.[3] Lung disease patients are part of these communities served by navigators. For example, almost half of children living with asthma are on the Medicaid program.

[3] Natale-Pereira A, Enard KR, Nevarez L, Jones LA. The Role of Patient Navigators in Eliminating Health Disparities. Cancer. 2011;117(15 0):3543-3552. doi:10.1002/cncr.26264.

Over the years, patient navigation has continued to evolve and is recognized as an effective means to facilitate access to quality medical care (including preventive care services) by identifying and bridging gaps in understanding and encouraging compliance, thereby reducing barriers to care.[4] The patient navigator program helps all patients, including those with lung disease, access quality and affordable care. The community-based, in-person navigators are vital to the continued success of the program and the healthcare marketplace in general. The Lung Association urges the Department to remove this provision in the final NBPP rule.

Medical Loss Ratio (MLR) Standards

Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirement, proposes changes to the MLR. The MLR is a key patient protection to ensure that between 80 and 85 percent of premium dollars go towards patient care and not towards profits for insurance companies. Currently insurance companies have to provide documentation that they are spending the correct percentage of premium dollars on patient care; if not, patients receive a rebate. The proposed rule, in section 158.221, allows insurance companies to report a MLR of 80 percent rather than "report the issuer's actual expenditures for actives to improve health care quality".

The American Lung Association is very troubled by this proposal. Without reporting the issuer's actual expenditures, there is no way to verify the 80 percent MLR. This is harmful to lung disease patients as it could result in increased premiums with less healthcare delivered, as issuers would no longer have to document meeting the 80 percent MLR. This provision has had great success. In 2012, consumers received over a billion dollars in rebates; however, in 2016, consumers only received $397 million in rebates.[5] By requiring the reporting of actual expenditures and reimbursement to consumers, this provision has led issuers to change their behavior. If the requirement of reporting actual expenditures is removed, this would result in higher premiums than are necessary for the care that patients received.

This section also provides an option for states to establish their own MLR. The Lung Association opposes this proposal. If a state wants to waive the 80 percent MLR they should seek to waive it through the 1332 waiver process and provide evidence that it will not increase premiums or reduce coverage, per the statutory requirements of the 1332 waiver process.[6]

---

[4] Moy B, Chabner BA. Patient Navigator Programs, Cancer Disparities, and the Patient Protection and Affordable Care Act. The Oncologist. 2011;16(7):926-929. doi:10.1634/theoncologist.2011-0140.

[5] "The 2019 Proposed Payment Notice, Part 1: Insurer And Exchange Provisions, " Health Affairs Blog, October 28, 2017.DOI: 10.1377/hblog20171028.684065

[6] United States Congress. *Patient Protection and Affordable Care Act, 42 USC 18001.* Public law. 111-148. https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf. January 5, 2010.

Network Adequacy

In the Market Stabilization rule, HHS announced it would rely on states for Qualified Health Plan (QHP) certification related to network adequacy and essential community providers (ECPs).[7] The Department now indicates that it will continue this policy for plan year 2019 and beyond.

The Lung Association agrees with the Department that states should play a role in the structure and management of their exchanges; however, we are concerned that continuing this policy may result in unequal access to important consumer protections. While some states may choose to enact strong network adequacy requirements and/or ECP policies – and devote significant resources to determining that issuers are complying with the requirements – not all states are positioned to do so. In order to ensure consistency of the network adequacy and ECP provisions, federal oversight is warranted.

The Lung Association urges the Department to establish higher standards for ECPs. Lung disease disproportionately impacts low-income populations and it is critical those patients are able to see providers in their communities that are accessible to them.

Minimum Essential Coverage

The Department asks for comment on whether Medicaid Buy-In programs should be designated as Minimum Essential Coverage (MEC) without submitting an application. The Lung Association urges the Department to allow Medicaid Buy-In programs that provide benefits equivalent to the VIII group to be automatically designated as MEC. In an effort to stabilize the marketplace and increase competition, the Lung Association believes states should have the flexibility to offer a Medicaid Buy-in program.

Other Considerations

The American Lung Association believes all patients should have access to quality and affordable care that allows for guidelines-based treatment. As such, we urge the Department to ensure coverage for asthma care, tobacco cessation and other diseases cover the necessary treatments so providers can furnish guidelines-based care to their patients.

To ensure patients have guidelines-based care, benchmark plans should cover the National Asthma Education and Prevention Program (NAEPP) guidelines, including robust medications coverage. Tobacco is leading cause of preventable death in the United States and quitting smoking is the single best thing a person can do for their health. To save both money and lives, the Lung Association strongly encourages benchmark plans to cover a tobacco cessation benefit modeled off of the Public Health Services Treating Tobacco Use and Dependence Clinical Practice Guidelines

[7] Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 18346-18382 (April 18, 2017). https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization

2008 Update and the United States Preventive Services Task Force (USPSTF) 2015 Recommendation. This can be achieved by modeling the benefit on the Federal Employee Health Benefits plan's cessation benefit.[8]

Lastly, there are many treatments receiving an "A" or "B" by the USPSTF that are prescription drugs and appear on a formulary. The Lung Association strongly encourages the Department to incentivize issuers to create formularies with a $0 co-pay tier, as these preventive services medications are not subject to cost-sharing. This simple designation would add clarity for consumers, including smokers who are trying to quit.

The American Lung Association appreciates the opportunity to submit comments on this important rule and urges the Department to keep patients in the forefront when creating new policies that impact the accessibility, adequacy and affordability of healthcare.

Sincerely,

Harold P. Wimmer
National President and CEO
American Lung Association

CC: The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services

[8] Office of Personnel Management. Federal Employee Health Benefits: Special Initiatives: Quit Smoking. Found at: https://www.opm.gov/healthcare-insurance/special-initiatives/quit-smoking/

Appendix A

Consensus Healthcare Reform Principles

Today, millions of individuals, including many with preexisting health conditions, can obtain affordable health care coverage. Any changes to current law should preserve coverage for these individuals, extend coverage to those who remain uninsured, and lower costs and improve quality for all.

In addition, any reform measure must support a health care system that provides affordable, accessible and adequate health care coverage and preserves the coverage provided to millions through Medicare and Medicaid. The basic elements of meaningful coverage are described below.

Health Insurance Must be Affordable – Affordable plans ensure patients are able to access needed care in a timely manner from an experienced provider without undue financial burden. Affordable coverage includes reasonable premiums and cost sharing (such as deductibles, copays and coinsurance) and limits on out-of-pocket expenses. Adequate financial assistance must be available for low-income Americans and individuals with preexisting conditions should not be subject to increased premium costs based on their disease or health status.

Health Insurance Must be Accessible – All people, regardless of employment status or geographic location, should be able to gain coverage without waiting periods through adequate open and special enrollment periods. Patient protections in current law should be retained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender pricing and excessive premiums for older adults. Children should be allowed to remain on their parents' health plans until age 26 and coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Insurance Must be Adequate and Understandable – All plans should be required to cover a full range of needed health benefits with a comprehensive and stable network of providers and plan features. Guaranteed access to and prioritization of preventive services without cost-sharing should be preserved. Information regarding costs and coverage must be available, transparent, and understandable to the consumer prior to purchasing the plan.