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February 19, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-9926-P/RIN 0938-AT37
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020

Dear Administrator Verma:

We appreciate the opportunity to provide written comments on HHS' proposed rule, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020."¹

The National Health Law Program is a public interest law firm working to advance access to quality health care. Founded in 1969, we protect and advance the health rights of low-income and underserved individuals and families by advocating, educating, and litigating at the federal and state levels.

Our specific comments are provided on the following pages.

Automatic Reenrollment

The preamble sought comment on reenrollment policies, mentioning that some consumers may be less aware of their options year to year and that "automatic reenrollment eliminates an opportunity for consumers to update their coverage and premium tax credit eligibility as their personal circumstances change. . ." ² While we recognize that some consumers who are auto re-enrolled could receive less tax credits or miss options to select a plan better suited to them, the alternatives are much more dire. Without auto reenrollment, many consumers may end up without coverage altogether.

HHS notes potential government misspending as one effect. Given that consumers receiving tax credits must still reconcile advanced tax credits at the end of each tax year, we are hard pressed to understand what misspending may occur. Further, with some of the policies HHS has implemented through recent NBPP rulemaking, including adding data matching inconsistencies for consumers who are at or near the federal poverty level, we believe any potential minimal misspending is outweighed by maintaining coverage for consumers who otherwise may not renew their coverage.

§ 155.210 – Navigator Program Standards

We are very concerned about the proposed changes to the Navigator Program Standards. For over six years, the National Health Law Program has provided technical assistance to thousands of navigators and assisters across the country as they support consumers with enrollment and post-enrollment activities. We have heard about the successes and challenges navigators have had in educating consumers about the Affordable Care Act and Medicaid. We have heard about the challenges they have had in navigating healthcare.gov, assisting consumers with data matching inconsistencies and resolving appeals, and how much time and energy they spend with each consumer to ensure the consumer enrolls, selects a plan, resolves any issues, and knows how to use their plan. Without navigators, the numbers of uninsured in this country would be much higher.

Thus we are very concerned about HHS' continued actions that reduce the ability of navigators to effectively assist consumers. We opposed not only HHS' funding cuts but also HHS' previous regulatory changes that allowed only one navigator entity per state and rescinded requirements that navigators have an in-state presence. We believe the current proposals continue HHS' efforts to undermine the consumer assistance requirements of the Affordable Care Act.

While HHS states the reason for the proposed changes this year is due to reduced funding available for navigators, the direct cause of this reduced funding is HHS' decision to cut 84% from 2016 funding. According to Kaiser tracking polls, most people, and particularly those who are uninsured, have limited awareness about open enrollment.³ Further, consumers seeking help had limited understanding of the eligibility and enrollment process, of health insurance, and lacked confidence to apply on their own.⁴

Instead, HHS seems to be shifting responsibilities to agents and brokers more than navigators. Yet, brokers are significantly less likely than navigators to help individuals who are uninsured, have limited English proficiency, or who lack internet at home.⁵ In addition, brokers are far less likely to help

¹ See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 227 (Jan. 24, 2019).

² 84 Fed. Reg. 229.

³ Karen Pollitz, Jennifer Tolbert and Maria Diaz, *Data Note: Further Reductions in Navigator Funding for Federal Exchange States*, Kaiser Family Foundation, Sep. 24, 2018, <https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-exchange-states/>.

⁴ *Id.*

⁵ *Id.*



complete applications for Medicaid or CHIP for low-income consumers who discover they are not eligible for premium tax credits but may be eligible for public plan coverage.⁶

Rather than continue to curtail funding and responsibilities of navigators, HHS should instead increase funding and maintain the existing requirements.

In particular, we oppose changes to reduce requirements for navigators to provide post-enrollment assistance and elimination of training requirements related to serving individuals with limited English proficiency and individuals with disabilities.

Post-Enrollment Assistance is Critical for Many Consumers

The proposed rule would eliminate requirements that navigators provide consumers help with:

- understanding the process of filing exchange eligibility appeals;
- understanding and applying for exemptions from the individual shared responsibility payment that are granted through the exchange;
- the exchange-related components of the premium tax credit reconciliation process;
- understanding basic concepts and rights related to health coverage and how to use it; and,
- referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice on certain exchange-related topics.⁷

While we recognize reduced navigator funding has led some navigator entities to focus their assistance on enrollment, many consumers need help post-enrollment. Some consumers may have data matching inconsistencies and need help resolving them. Some consumers may receive inaccurate eligibility determinations and need to learn about appeals. All consumers receiving APTCs will need to reconcile APTCs on their federal tax forms and could benefit from referrals to tax assistance. And consumers who were previously uninsured or underinsured likely would greatly benefit from education about how to use their health coverage. And these needs do not disappear with the passage of time because every year new consumers enter the exchange (due to cycling on/off Medicaid, CHIP, or private insurance) or have new issues arise with exchange reenrollment that they may not have had previously. This is especially the case as HHS continues to change the regulations regarding when consumers may be subject to an income inconsistency and eligibility for SEPs.

Rather than reduce responsibilities of navigators, we believe HHS should increase funding to maintain these essential services.

Training on Nondiscrimination Requirements Protects Consumers and Navigator Entities

HHS also proposes eliminating a number of requirements related to training of navigators. First, HHS would eliminate training requirements on the topics described above that would no longer be required

⁶ *Id.*

⁷ 84 Fed. Reg. 234, 268.



of navigators. As we noted above, we oppose rescinding these requirements. And since consumers will continue to ask questions about these issues of navigators and some navigator programs will continue to provide these services, we believe all navigators should still be trained on these issues.

Further, HHS would eliminate training on the following topics:

- outreach and education methods and strategies;
- appropriate contact information for other agencies for consumers seeking information about coverage options not offered through the exchange;
- working effectively with individuals with limited English proficiency, and disabled, rural, underserved or vulnerable individuals;
- providing linguistically and culturally appropriate services;
- ensuring physical and other accessibility for people with a full range of disabilities; and
- applicable administrative rules, processes and systems related to exchanges and QHPs.

We are very concerned about the elimination of all of these topics. Agents and brokers tend not to seek out and serve hard-to-reach populations including residents of rural areas, immigrants, LGBTQ individuals, individuals with disabilities, and individuals with limited English proficiency. Other requirements governing navigator responsibilities make serving these underserved populations a key component of navigator responsibilities. Thus, we believe all navigator entities should have training on these topics to help them understand the particular issues these groups may face and how to help them.

In particular, all navigator entities, as recipients of federal funds, must comply with Section 1557 of the ACA, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. The training provided offers these entities basic knowledge essential to meeting these requirements and working with individuals with disabilities or limited English proficiency. The requirement to comply with these laws remains yet HHS would rescind the tools that can provide navigator entities with essential information to meet these requirements. We believe it is shortsighted to eliminate these training requirements and could lead to navigator entities unknowingly violating anti-discrimination provisions.

We strongly recommend that HHS continue to provide training on these topics.

§ 155.420 – Special Enrollment Periods

We support the addition of a Special Enrollment Period (SEP) for consumers who have off-exchange coverage and become newly eligible for APTCs. As HHS recognizes, an SEP already exists for consumers in this situation with employer-sponsored coverage (ESI) so the new SEP provides equity for those who do not have ESI.



§ 156.111 – State Selection of EHB Benchmark Plan for Plan Years Beginning on or After January 1, 2020

We continue to strongly oppose the new EHB benchmark options that HHS finalized in the 2019 Notice of Benefit and Payment Parameters final rule. These options open the door to less comprehensive coverage for consumers, which will disproportionately impact individuals with disabilities and people with pre-existing medical conditions who could face reduced access to needed services and medical debt as a result of higher out-of-pocket costs. A robust EHB standard is essential to individuals receiving effective care. HHS recognized that offering less coverage might result in “spillover” effects, including increased use of emergency services and other services provided by safety net and government-funded providers.⁸ This not only affects the individual patient but also affects our productivity as a nation, and ultimately increases the cost of health care.

States should be encouraged to address the opioid epidemic through EHBs, but not by limiting access to necessary care

We appreciate that HHS is actively encouraging states to explore whether modifications to their EHB benchmark plan would be helpful in addressing the opioid epidemic. However, we emphasize the importance of modifying EHBs in a way that provides individuals with or at risk of opioid use disorders with access to comprehensive care options. For example, we strongly support state policies that require health plans to cover the complete array of substance use disorder (SUD) treatment options, including all medications used for medication-assisted treatment. In addition, benchmark plans that provide comprehensive coverage of non-opioid alternatives for pain treatment should be encouraged. However, we caution against measures that seek to curb the opioid epidemic by imposing strict limits on the doses of opioids for treating pain. While we support efforts to improve opioid prescribing practices, this should not happen at the expense of individuals who need access to these medications to treat their conditions. Our experience has been that such policies disproportionately affect low-income people who have difficulty accessing medically necessary care.

HHS must enforce state level notice and comment requirements and should provide an opportunity for federal comments

We urge HHS to consider the need for states to comply with ***notice and comment requirements*** in setting the deadline for states to submit all necessary documents if they are changing their EHB benchmark plan for the 2021 or 2022 plan years. Before submitting a new benchmark plan selection to HHS, states are required to provide:

reasonable public notice and an opportunity for public comment on the State’s selection of an EHB-benchmark plan that includes posting a notice on its opportunity for public comment with *associated information* on a relevant State Web site (emphasis added).⁹

⁸ Preamble of the NBPP for 2019 proposed rule, 82 Fed. Reg. 51131.

⁹ 45 C.F.R. § 156.111(c).



The only reasonable interpretation of this provision is that states are required to provide an ample opportunity for public comment. Advocates and stakeholders must have sufficient time to review the proposed changes to the state's EHB benchmark plan and any associated documents in order to determine whether they will meet the needs of the state's population. The state in turn reviews the public's comments and modifies the proposal accordingly. But in order to provide meaningful feedback, advocates and stakeholders must receive all relevant information, including: 1) detailed information about the proposed changes, 2) whether the state is using the benchmark plan from another state, and 3) the actuarial report the state intends to submit to HHS. It is critical that HHS enforce these state-level procedural requirements.

We also recommend that in addition to the state level comment period, HHS provide a federal comment period on the proposed EHB benchmark changes. When states had an opportunity to change their EHB benchmark plan selection in 2015, HHS gave advocates and stakeholders an opportunity to evaluate and comment on the proposed EHB benchmark plans, and posted plan documents for advocates and stakeholders to review prior to submitting comments. To our surprise, this process did not take place for evaluation of Illinois' proposed EHB benchmark plan for 2020. We urge HHS to provide a federal comment period on proposed EHB benchmark changes in order to ensure a completely transparent process.

§ 156.115 – Provision of EHB

We continue to strongly oppose allowing benefit substitution ***both within and between*** EHB categories. In the NBPP for 2019, HHS finalized a policy that allows states to permit issuers to substitute benefits between EHB categories. This substitution of benefits policy will result in coverage gaps and higher out-of-pocket costs for consumers in need of services not covered by the issuer. This will also make it difficult for consumers to compare health coverage options, making plan selection challenging. HHS recognized that benefit substitution between EHB categories would increase the burden on consumers, as they would “need to spend more time and effort comparing benefits offered by different plans in order to determine what, if any, benefits have been substituted and what plan would best suit their health care and financial needs.”¹⁰ In addition, without a standard set of EHBs that issuers must cover, it is unclear how state regulators would ensure adequate coverage of EHBs. HHS noted that by allowing substitution between categories, states “may encounter difficulties in ensuring that all categories are filled in such a way that amounts to EHB”.¹¹ This will open the door for inadequate coverage of the ten EHB categories. Therefore, we continue to urge HHS not to allow issuers to substitute benefits between EHB categories.

¹⁰ 82 Fed. Reg. 51131.

¹¹ *Id.*



**§ 156.130 – Application to Cost-Sharing Requirements and Annual and Lifetime Dollar Limitations
and
§ 146.152, § 147.106, and § 148.122 – Guaranteed Renewability of Coverage**

In the proposed rule, HHS states, “[w]e are committed to promoting a consumer-driven health care system in which consumers are empowered to select and maintain health care coverage of their choosing.”¹² We agree with this goal. However, proposals within the NBPP 2020 proposed rule would have the opposite effect by limiting consumer choice and access to prescription drugs while increasing costs.

Mid-year formulary changes can be harmful to consumers

Under current rules, issuers may only modify plan benefits, including formularies for outpatient prescription drugs, at the time of open enrollment.¹³ However, despite this federal requirement, advocates report numerous incidents where issuers adversely change benefits in the course of the plan year, such as increasing cost sharing, imposing prior authorization, step therapy, or other requirements, and dropping certain drugs from plan formularies.¹⁴ Such changes can be particularly harmful for people with certain medical conditions where there is no one-size-fits-all treatment regimen and medication needs are highly individualized.¹⁵ HHS recognized the harm that can come to consumers through mid-year changes to formularies, but acknowledged that changes may be appropriate in some circumstances, for example, to comply with nondiscrimination requirements or add a newly approved drug to a plan’s formulary.¹⁶

Accordingly, in 2017 HHS established new mechanisms to help ensure that plan formularies are up to date and adequately meet consumers’ needs. HHS now requires issuers to establish Pharmacy and Therapeutics Committees, which must meet at least quarterly to review plan formularies, prior authorization criteria and other medical management strategies, and document the rationale for all decisions regarding formulary drug list development or revision.¹⁷

¹² 84 Fed. Reg. 228.

¹³ 45 C.F.R. § 147.106(e).

¹⁴ See e.g., NAIC, *Promoting Access to Affordable Prescription Drugs: Policy Analysis and Consumer Recommendations for State Policymakers, Consumer Advocates, and Health Care Stakeholders* (Aug. 2016), <https://advocacy.consumerreports.org/wp-content/uploads/2016/08/Promoting-Access-to-Affordable-Prescription-Drugs-Aug-2016.pdf>. HHS has previously stated that states, as the traditional regulators of insurers, are primarily responsible for EHB and other protections. Ctrs. Medicare & Medicaid Servs, Final 2016 Letter to Issuers in the Federally-Facilitated Exchange 37-38 (Feb. 20, 2015).

¹⁵ See, e.g., Alexia Elejalde-Ruiz, *Her daughter's epilepsy was under control, but then their insurer stopped covering the drug: 'It's devastating,'* CHICAGO TRIBUNE (March 14, 2018), <https://www.chicagotribune.com/business/ct-biz-illinois-nonmedical-switching-bill-0315-story.html>.

¹⁶ 80 Fed. Reg. 10822.

¹⁷ 45 C.F.R. § 156.122(a)(3).



Prescription drug coverage is a key factor in plan selection for many consumers, especially those with significant health needs and chronic conditions. For this reason, the ACA allows consumers to shop and compare plans through the standardized “Summary of Benefits and Coverage.” In addition, advocates urged and HHS adopted transparency requirements for plans to publish their prescription drug formularies along with information on cost sharing and prior authorization requirements.¹⁸ A plan’s formularies must be easily accessible to consumers prior to plan selection, with the capacity to develop a machine-readable format to allow consumers to easily compare drug coverage across plans.¹⁹

However, the proposed NBPP 2020 would radically depart from HHS’ earlier efforts to strengthen consumer protections. If finalized, the NBPP 2020 would not only allow plans to drop prescription drugs from formularies mid-year but actually encourage plans to do so. This proposal would harm consumers, particularly those with significant health needs for whom prescription drug coverage is paramount. Moreover, HHS’ proposal to eliminate coverage of brand drugs when a generic becomes available would arbitrarily cap an essential health benefit, contrary to congressional intent authorizing HHS to establish minimum coverage standards.

We agree that when a generic, equivalent version of brand drug becomes available, plans should be permitted to add that drug to its formulary. Expanding formularies increases consumer choice and provides greater access to generics, which can be equally effective and less expensive than brand drugs.

We also agree that plans should have the opportunity to encourage providers to prescribe a less expensive equivalent version of a brand drug, which may entail moving the brand drug to a higher cost sharing tier, or imposing prior authorization, step therapy, or other utilization controls. However, such changes should be subject to adequate notice to consumers who rely on those drugs, with an effective exceptions process to continue access to the brand drug when clinically appropriate.²⁰

We strongly disagree with HHS’ proposal to allow issuers to remove medications from formularies, which would harm consumers who rely on those medications.

Undermining EHB standards would have far-reaching effects

In the proposed rule, HHS would allow issuers to remove the brand drug from its formulary when a generic becomes available. If a plan covers a brand drug where a generic exists, the brand drug would no longer be considered EHB.²¹ This proposal, which encourages plans to drop brand drugs, would have serious, far-reaching implications across the health care landscape:

¹⁸ 45 C.F.R. § 156.122(d)(e).

¹⁹ *Id.*

²⁰ HHS indicates that it will seek comment on the content of notices through a PRA process. 84 Fed. Reg. 234.

²¹ 84 Fed. Reg. 289-290.



- plans subject to EHB protections would no longer be required to count co-pays of drugs toward out-of-pocket maximums for drugs outside of EHB, thereby driving up costs for consumers;
- premium tax credits (PTCs) could not be applied to any portion of the premium attributable to coverage of brand name drugs not covered as EHB, requiring plans to allocate premiums among enrollees; and
- ACA protections against annual and lifetime caps on benefits would no longer apply to prescription drugs designated as non-EHB, putting consumers at risk for denials of needed care and medical-related bankruptcy.

This proposal presents a dangerous attempt to undermine the EHB protections established by Congress by carving out essential benefits and designating them as non-EHB. Ominously, HHS suggests it may apply this approach to undermine other EHB categories, such as durable medical equipment (DME) provided as part of habilitative and rehabilitative services.²²

In addition, HHS fails to consider how removing certain drugs from formularies and EHB protections affects the ACA's non-discrimination requirements. HHS has previously concluded that failure to cover single-tablet therapy, whereby several drugs are combined in a single tablet, is a potentially discriminatory benefit design.²³ Combination therapy is standard of care in HIV treatment, and is common for other conditions including diabetes, but is typically not counted as part of the EHB minimum of one drug per class and category.²⁴

Current regulations specify that “[a]n issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.”²⁵ By removing important treatments from formularies and EHB protections, the proposed rule would create a Catch-22, resulting in plans with discriminatory benefit design, in violation of EHB.

Given the likely harmful consequences to persons who depend on prescription drug coverage, in addition to the confusion and administrative complexity (which would likely outweigh any cost savings), we strongly oppose these changes.

²² 84 Fed. Reg. 235.

²³ U.S. Dep’t of Health and Human Svcs., Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750, 10,822 (Feb. 27, 2015), <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>.

²⁴ 45 C.F.R. § 156.122(a)(19)(i). Dept. Health & Human Svcs., Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents (last updated Oct. 25, 2018) (last accessed Jan. 27, 2019), <https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf>; Pharmaceutical Researchers and Manufacturers Assoc., Access to Combination Therapies in Exchange Plans, <http://phrma-docs.phrma.org/sites/default/files/pdf/Exchanges-combination-therapies.pdf>.

²⁵ 45 C.F.R. § 156.125.



HHS should withdraw the proposal to allow issuers to remove drugs from formularies and eliminate EHB protections and enforce current regulations that bar plan modifications at times other than open enrollment, but allow issuers to add drugs to formularies.

The exceptions processes, as implemented, provide inadequate protection for consumers

Current regulations provide a standard, expedited, and external-review exceptions process to allow consumers to access non-formulary drugs in plans subject to EHB standards.²⁶ HHS provided guidance for plans in establishing and operating their exceptions processes, including informing requirements.²⁷

Non-formulary prescription drugs available to enrollees through the exceptions process can be a critical component of the enrollee's treatment plan. For example, cancer patients often require the use of a health plan's exceptions process to "obtain products and services necessary to treat their condition."²⁸

In the proposed NBPP 2020 rule, HHS assures that persons would still be able to use the exceptions process to access brand drugs removed from a plan's formulary or to continue the brand drug's designation as EHB.

In the 2016 NBPP rulemaking, we strongly advocated for more robust consumer protections, including an effective exceptions process.²⁹ We also urged HHS to monitor the exceptions process to determine ease of use and to identify coverage gaps.³⁰ HHS appears to track whether plans have exceptions process as part of QHP certification.³¹ However, to date, we have seen no data or analysis from HHS on the use of, or evaluating the effectiveness of, the current EHB prescription drug exceptions processes. Last year, HHS announced that it would not conduct active certification reviews for prescription drug formulary and cost sharing outliers for states in 2018 and beyond.³²

²⁶ 45 C.F.R. § 156.122(c).

²⁷ U.S. Dep't of Health and Human Svcs., Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750, 10,818 (Feb. 27, 2015), <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>.

²⁸ American Cancer Society Cancer Action Network, Re: CMS-9944-P – Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016 (Dec. 22, 2014), <http://www.regulations.gov/#!documentDetail;D=CMS-2014-0152-0209>.

²⁹ Nat'l. Health Law Program, Re: CMS-9944-P – Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016 (Dec. 22, 2014), <https://www.regulations.gov/document?D=CMS-2014-0152-0276>.

³⁰ *Id.*

³¹ Ctrs. for Consumer Information and Insurance Oversight, Key Priorities for Federally-facilitated Exchange Compliance Reviews for the 2019 Plan Year, <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Key-Priorities-FFM-2019.pdf> (accessed Feb. 11, 2019).

³² Ctrs. for Consumer Information and Insurance Oversight, Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-facilitated Exchanges for Plan Years 2018 and Later, at 3, (April 13, 2017), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QHP-Certification-Reviews-Guidance-41317.pdf>.



As one example of problems with the exceptions process, the National Health Law Program has received reports raising concerns with the exceptions process for contraceptives provided under EHB.³³ Under current rules, if a woman's provider determines that the specific contraceptives covered without cost-sharing in the plan formulary are medically inappropriate for her, the plan must have a exceptions process in place to ensure that she can obtain the appropriate contraceptive without cost-sharing.³⁴ We have not heard of a single provider successfully using the exceptions process when their prescribed contraceptive is denied. Instead, providers typically are forced to prescribe a covered "second best," seeking to avoid a complicated and time-intensive consumer exceptions process.

Further, the exceptions process is unduly burdensome for consumers who must undergo a new determination upon the expiration of prescription drugs refills. Some prescription drugs may not be refilled and require a new prescription for every 30-day regimen.³⁵ Some patients with chronic pain would be required to undergo a new exceptions proceeding on a monthly basis to obtain medically necessary, non-formulary treatment.

Having effective, accessible exceptions processes for standard and expedited reviews, as well as an external review process, is essential for health care consumers who need access to potentially life-saving, non-formulary drugs. Such processes will be even more important if HHS finalizes the NBPP 2020 rule as proposed, and significantly limits access to brand drugs and removes EHB cost sharing and other protections.

Therefore, before expanding the role of the EHB exceptions processes, HHS should conduct a thorough and independent analysis of compliance, utilization, and outcomes. HHS should make the data and results of that analysis publicly available to serve as the basis for corrective action plans and additional guidance to state regulators and plans to ensure the EHB exceptions process is fully functional and meeting the needs of health care consumers, particularly those with disabilities, chronic conditions, or other significant health needs.

§ 156.280 – Segregation of Funds for Abortion Services

We are extremely concerned about the administration's efforts to use its administrative powers to gut access to the full range of health care services, including reproductive health care. Just last month, CMS completed their comment period on proposed changes to the program integrity requirements of the exchanges, including abortion coverage provisions that would make buying QHPs more confusing

³³ Health plans subject to EHB requirements must also cover all Food and Drug Administration (FDA) approved contraceptive methods without cost-sharing as preventive services. 45 C.F.R. § 156.115(a)(4); U.S. Dep't of Health and Human Svcs., Health Res. and Svcs. Admin., Women's Preventive Services Guidelines (Aug. 1, 2011), <http://www.hrsa.gov/womensguidelines/>.

³⁴ U.S. Dep't of Health and Human Svcs., U.S. Dep't of Labor, and U.S. Treasury, FAQs on Affordable Care Act Implementation XII, Question 14 (Feb. 20, 2013), http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html.

³⁵ See, e.g., Schedule II medications <https://www.deadiversion.usdoj.gov/faq/prescriptions.htm#rx-3>.

and costly for consumers. On the heels of these proposed regulations, HHS again proposes regulatory changes that will risk the sustainability of the exchanges and the availability of reproductive health services.

For these reasons, we strongly oppose the proposed changes to § 156.280. The Affordable Care Act provided the ability to purchase and enroll in health insurance to millions of individuals who did not previously have coverage. In an effort to provide comprehensive health care coverage, Congress permitted states as well as qualified health plans (QHPs) to offer comprehensive reproductive health services, including abortion, through the individual market exchanges. The proposed changes to § 156.280 conflict with the intent of the Affordable Care Act to allow abortion coverage in the exchanges. Requiring the creation of mirror plans that exclude non-excepted abortions will harm consumers, insurers, and the exchanges, putting access to health care services further out of reach.³⁶

The proposed requirement contravenes the intent of the Affordable Care Act

The Affordable Care Act affirmatively requires that certain services be provided and does not list any services that should be excluded. Congress rejected amendments aimed at overly stringent restrictions or prohibitions of abortion coverage during the health care reform debate and negotiations.³⁷ The final language of ACA § 1303 established that states had the authority to mandate or restrict abortion coverage in the exchanges, with the only additional requirement that federal funding could not be

³⁶ Non-Hyde or non-excepted abortion services refer to abortion services for which federal funding is prohibited. The Hyde Amendment only allows federal funding of abortion when a pregnancy is the result of rape or incest, or when it is necessary to save the patient's life. See Consolidated Appropriations Act, 2016, Pub. L. No. 114-113 § 507(c), <https://www.congress.gov/114/plaws/publ113/PLAW-114publ113.pdf>

³⁷ The Senate refused to adopt the Stupak-Pitts Amendment, which would have banned coverage of abortion in the exchanges, as well as barred federal subsidies for any QHP that covered abortion in cases other than rape, incest, or risk to the pregnant individual's life. See Amendment to H.R. 3962, 111th Cong. (2009) (offered by Rep. Stupak and Rep. Pitts), 155 CONG. REC. H12,921 (Nov. 7, 2009), available at <http://documents.nytimes.com/the-stupak-amendment>. In addition, the Senate rejected the Nelson-Hatch Amendment which had a similar goal to ban coverage of abortion services in the exchanges. See e.g., 155 CONG. REC. S12,665 (2009) (statement of Sen. Patty Murray): "All Americans should be allowed to choose a plan that allows for coverage of any legal health care service, no matter their income, and that, by the way, includes women. But if this amendment were to pass, it would be the first time that Federal law would restrict what individual private dollars can pay for in the private health insurance exchange." <https://www.congress.gov/congressional-record/2009/12/08#daily-digest-senate>; *id.* at S. 12,666; (statement of Sen. Ben Cardin): "The Nelson-Hatch amendment would go beyond that. It would restrict a woman's ability to use her own funds for coverage to pay for abortions. It blocks a woman from using her personal funds to purchase insurance plans with abortion coverage. If enacted, for the first time in Federal law, this amendment would restrict what individual private dollars can pay for in the private insurance exchange."

directed towards non-expected abortion coverage.³⁸ Within that context, issuers have the option to cover or not to cover non-expected abortions as part of their QHPs.

The proposed requirement creates unduly and burdensome hurdles for issuers and will increase costs for consumers

By the administration's own admission, the proposal will increase issuers' burden to develop, review, and maintain new QHPs, which include, "adding additional resources to create additional plan designs and administer additional plans."³⁹ But the burdens are far more significant. In order to create a mirror plan without non-expected abortion coverage, an issuer will have to adjust its systems and implement billing changes, price the product, file the plan and seek approval from CMS, notify enrollees, address enrollees' questions and complaints, and engage in ongoing maintenance and reporting.

Issuers may not be able to absorb the costs of adding new QHPs , and may stop offering abortion coverage or pass on the costs to enrollees

The administration also recognizes that, as a direct result of this proposal, issuers may decide to drop non-expected abortions in their QHPs.⁴⁰ By the administration's own account, when issuers drop coverage, individuals will lack options when enrolling in plans that cover abortion care. Individuals needing abortion services will have to pay for this care out-of-pocket, or be forced to keep their pregnancies. It is also possible that some issuers will increase premiums for QHPs that cover non-expected abortions, making it more expensive for consumers who seek to purchase QHPs. The administration's proposal shows clear disregard for individuals seeking abortion services, in particular low-income women and women of color, who will endure the hardest impact of this nonsensical policy. The proposal is contrary to the NBPP's proposed goal of empowering consumer choice and expanding health care coverage.⁴¹

Moreover, the proposed rule duplicates the onerous requirements that are in effect for Multi-state Plans ("MSPs"), which have resulted in very limited abortion coverage under these plans. MSP issuers were required to offer at least one option without coverage for non-expected abortion services.⁴² In 2016, of the 261 existing MSPs, only four covered non-expected abortion services.⁴³ These proposed changes will have the same devastating effect of eliminating abortion coverage from the exchanges.

³⁸ Amendment No. 2962 to Amendment No. 2785, 111th Cong. (2009) (offered by Rep. Nelson), 155 CONG. REC. S, 12, 600 (2009), available at <https://www.congress.gov/congressional-record/2009/12/07/senate-section/article/S12565-1>; see also ACA § 1303(b)(1), 42 U.S.C. § 18023(a).

³⁹ 84 Fed. Reg. 309.

⁴⁰ *Id.*

⁴¹ *Id.* at 228.

⁴² 45 U.S.C. § 800.602(a).

⁴³ Alina Salganicoff et al., Kaiser Family Found., *Coverage for Abortion Services in Medicaid, Exchange Plans and Private Plans* (2016), <https://www.kff.org/report-section/coverage-for-abortion-services-in-medicaid-exchange-plans-and-private-plans-issue-brief-8829/>.

This proposal further marginalizes the coverage and provision of abortion services and threatens the health and well-being of individuals who need abortion care

By requiring every issuer offering a QHP that covers non-excepted abortions to offer a mirror plan with only excepted abortions, this administration is punishing issuers that want to offer the most comprehensive health services for their enrollees. Unlike any other service, the proposal singles out this safe and common medical procedure for overly burdensome restrictions.⁴⁴ Existing federal restrictions on insurance coverage, coupled with increasing federal and state attacks on access to abortion care, often render the constitutional right to abortion meaningless. Already, too many individuals are denied abortion coverage because of how much they earn, where they live, or how they are insured. For many, coverage for abortion care means the difference between getting the health care they need when they need it and being denied that care.

Without insurance coverage, low-income women in particular have to raise the funds to pay out of pocket for an abortion. The time that it takes to raise funds for abortion care often results in delays, which in turn increases the cost of care. In a 2014 study, the average costs to patients for first-trimester abortion care was \$461, and anywhere from \$860 to \$1,874 for second-trimester abortion care.⁴⁵

These delays can result in complete denial of abortion care as some states have imposed gestational age restrictions on abortion services. The impact of such a denial can have long-term, devastating effects on a woman and her family's economic future. Many women who seek an abortion are experiencing economic hardships when they seek this care. Additionally, women who were denied abortion care were more likely to be the sole caretakers of their children in comparison to women who were able to receive the abortion care they needed.⁴⁶ This further demonstrates that women are making health care decisions that are best for themselves and their families. The proposed changes could very well expose many individuals and families to untenable economic circumstances. This is particularly true for women of color and LGBTQ individuals of color who disproportionately struggle with poverty.⁴⁷

⁴⁴ Nat'l Acad. of Sci., Eng'g and Med., *The Safety and Quality of Abortion Care in the United States*, (Mar. 16, 2018), <http://www.nationalacademies.org/hmd/Reports/2018/the-safety-and-quality-of-abortion-care-in-the-united-states.aspx> (finding that abortion in all forms is a safe and effective form of health care).

⁴⁵ See All Above All & Ibis Repro. Health, *The Impact of Out-of-Pocket Costs on Abortion Care Access* (2016), <https://ibisreproductivehealth.org/sites/default/files/files/publications/Brief%20OutOfPocket%20Impact.pdf>.

⁴⁶ *Id.*

⁴⁷ In 2016, women in all racial and ethnic groups were more likely than their white, non-Hispanic male peers to live in poverty. Kayla Patrick, Nat'l Women's Law Ctr., *Nat'l Snapshot: Poverty Among Women & Families, 2016 1* (2017), <https://nwlc-ciw49tixqw5lbab.stackpathdns.com/wp-content/uploads/2017/09/Poverty-Snapshot-Factsheet-2017.pdf>. LGBTQ people of color, particularly transgender and gender nonconforming persons of color, experience high rates of poverty. Movement Advancement Project, *Paying and Unfair Price: The Financial Penalty for Being LGBT in America* 6-8 (2014), <http://www.lgbtmap.org/file/paying-an-unfair-price-condensed-report.pdf>.



Additionally, women denied access to an abortion have been found to suffer adverse physical and mental health consequences. For example, according to a longitudinal study frequently cited in peer-reviewed journals, women denied abortions are more likely to experience eclampsia, death, and other serious medical complications during the end of pregnancy, more likely to remain in relationships where interpersonal violence is present, and more likely to suffer anxiety in the short term after being denied an abortion.⁴⁸ The proposed changes to abortion coverage will harm the health and economic well-being of consumers.

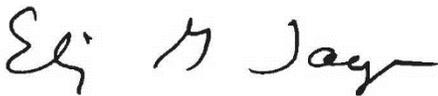
The proposed rule is statutorily inconsistent because it undermines states' authority over issuers

The proposal overrides states' authority over issuers that operate in their states. Section 1321 of the ACA provides for state flexibility in the operation and enforcement of exchanges and related requirements.⁴⁹ The proposed changes will disrupt the nature of collaboration and partnership that the Affordable Care Act meant to create between the states and the federal government.

Conclusion

Thank you for the opportunity to provide comments on the proposed rule. If you have any questions about our comments, please contact Mara Youdelman (youdelman@healthlaw.org) or Candace Gibson (gibson@healthlaw.org) at 202-289-7661.

Sincerely,



Elizabeth G. Taylor
Executive Director

⁴⁸ Univ. of California-San Francisco, *Turnaway Study*, <https://www.ansirh.org/research/turnaway-study> (last visited Jan. 4, 2019).

⁴⁹ ACA § 1321, 42 U.S.C. § 18041.

