November 27, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue SW
Washington, DC 20201

Via Electronic Submission

Attention: CMS-9930-P

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019

Dear Administrator Verma:

On behalf of the Association of Maternal & Child Health Programs (AMCHP), thank you for the Department’s work on the proposed rule and the opportunity to comment. AMCHP is a national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs. AMCHP members administer the Title V Maternal and Child Health (MCH) Services Block Grant program in each state, which provides a foundation for supporting systems for improving health and health care for all women, children and families.

General Comments

AMCHP has always supported a robust Essential Health Benefits (EHB) package to facilitate access to health care services for women, children, and families. The current EHBs as defined by the Patient Protection and Affordable Care Act (PPACA) provide essential services for MCH populations including coverage for maternity and newborn care, pediatric oral and vision care, and preventive care for all ages, among other benefits. The current EHB requirement has helped ensure access to basic health care services and has closed health care coverage gaps that existed prior to the requirement. For example, prior to the PPACA, 75% of non-group market plans did not cover maternity care (delivery/inpatient care). Scaling back on coverage of EHBs could significantly raise out-of-pocket costs for individuals who need such benefits, reduce affordable access to needed care, and cause individuals to forego necessary medical care, resulting in poorer health outcomes.

Specific Comments

§ 156.111(A) – States’ EHB-Benchmark Plan Options
We are concerned that new benchmark selection options could lead to reduced coverage in benefit categories that would impact the health of women, children, and families.
States currently have 10 benchmark plans to select from each year to help define each state’s essential health benefits package. We believe the current system best meets the PPACA legal requirement that the essential health benefits in a state be similar to a typical employer plan operating in that state. The current process provides states sufficient options and reflects the individual needs of each state. AMCHP supports the current flexibility afforded to states in selecting the EHB benchmark plan.

The proposed rule provides states with three options for updating a state’s EHB benchmark plan or with the option of maintaining the current 2017 EHB benchmark plan. We are concerned that the new EHB benchmark options will reduce the comprehensiveness of coverage for consumers by allowing states to drop or limit the benefits that are currently covered in their state, give insurers more latitude to deviate from a state’s EHB standard, and weaken consumer protections against catastrophic out-of-pocket costs in large employer plans. These changes would disproportionately impact individuals with disabilities and people with pre-existing medical conditions who could face reduced access to the services they need and higher out-of-pocket costs. In addition, reduction in benefit categories such as maternity and newborn care, pediatric services, rehabilitative and habilitative, and preventive services, could lead to adverse health outcomes for MCH populations.

§ 156.111(B)-(D) – The Requirement for States’ EHB-Benchmark Plans
AMCHP supports the proposed rule’s requirement that a state’s EHB-benchmark plan provide an appropriate balance of coverage for the 10 EHB categories established under section 1302(b)(1) of the PPACA.

AMCHP supports the proposed rule’s requirement that a state’s EHB-benchmark plan provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups as established under section 1302(b)(4)(C) of the PPACA.

§ 156.115 – Provision of EHB
The current EHB rule allows issuers to make actuarially equivalent substitutions within statutorily required benefit categories; the proposed rule allows issuers to make actuarially equivalent substitutions within and between benefit categories. AMCHP is concerned that cross-category substitution could lead to issuers substituting out critical benefits for MCH populations. We are concerned that issuers could substitute in lesser medical benefits that meet actuarial equivalence but are not as robust in providing key health care benefits. Furthermore, allowing issuers to substitute benefits within and between EHB categories will result in coverage gaps and higher out-of-pocket costs for consumers in need of services that are substituted and not covered by the issuer. This will also make it difficult for consumers to compare health coverage options, making plan selection challenging.

§ 156.235 – Essential Community Providers
The current requirement that Qualified Health Plan (QHP) networks must contract with Essential Community Providers (ECPs) who provide care to predominately low-income and medically-underserved populations is key to improving health outcomes and reducing health and health care disparities. Since QHPs serve large numbers of women of childbearing age, it is also crucially important that the U.S. Department of Health and Human Services (HHS) ensures that QHP networks include ECPs that can
serve the unique health needs of women.\textsuperscript{iv} Overall, we have been pleased by the strides HHS has taken toward ensuring participation by the full range of ECPs that currently comprise the safety-net of providers who provide health care to low-income communities. We oppose HHS’s proposals that will reduce ECP participation.

AMCHP is concerned with the proposal to reduce the requirement for ECP inclusion in QHP networks from 30% to 20% in the Federally-Facilitated Marketplace (FFM). Non-profit and publicly-funded clinics are critical to overall reproductive health of low-income individuals. ECPs that participate in both Medicaid and Marketplace plans’ networks provide continuous care to patients who move back and forth between private insurance and Medicaid eligibility because of changes in income.

By helping women avoid unintended pregnancies, ECPs play a vital role as providers of family planning services. A total of 6.2 million women received publicly funded family planning services from 10,700 clinics in 2015. Unintended pregnancies are declining – especially among adolescents. Without access to local, trusted, publicly funded community-based clinics, the unintended pregnancy rate would be 31% higher for adult women, and 44% higher for adolescents.\textsuperscript{V}

Furthermore, a significant number of safety net providers within every QHP network is essential to better birth outcomes. People of color face significant barriers in access to and utilization of care.\textsuperscript{vi} Nonelderly Asians, Hispanics, Blacks, and American Indians and Alaska Natives face increased barriers to accessing care compared to Whites, and have lower utilization of care. For example, the preterm birth rate for Black women is 24% – higher than for any other women. Black women experience higher rates of certain chronic conditions such as diabetes, hypertension, and sexually transmitted infections, which can result in poor birth outcomes if these conditions remain unidentified or unmanaged before women become pregnant.\textsuperscript{vii} In 2015, the infant mortality rates were 5.0% for Hispanic, 8.3% for American Indian/Native Alaskans and 11.3% for Non-Hispanic Black, compared to 4.9% for non-Hispanic Whites. More ECPs, not fewer, are critical to meeting the needs of these communities.

In Appalachia, for example, there is a widening disparity in infant mortality, higher rates of preterm birth, low birthweight, maternal diabetes, and maternal hypertension.\textsuperscript{viii} All of these conditions are indicators of greater need for medical services, yet Appalachia also faces a shortage of providers. Weakening the ECP standard will only exacerbate these concerns.

We are also deeply concerned that the proposed rule would severely weaken the ECP standards by no longer requiring state-based exchanges utilizing the federal platform to enforce ECP standards that are used for the FFM. Already, some state-based exchanges that do not use the federal platform have adopted less robust ECP standards.\textsuperscript{ix} Consumers in these states may have less access to providers that serve women of reproductive age and enrollees of color.\textsuperscript{v} Robust standards are needed to ensure that plans are providing access to the ECPs on which these communities rely.

In addition, HHS states that it will continue to allow issuers to use the ECP write-in process to identify ECPs that are not on the HHS list of available ECPs. We urge HHS to eliminate this option that permits issuers to forgo the ECP standard completely by submitting a narrative justification that describes why they could not meet the standard, but still have a network that is sufficient to meet the needs of low-
income and medically-underserved enrollees. This provision has the potential to become the exception that swallows the rule. Without an adequate number of legitimate ECPs in an issuer’s network, women and communities of color who rely on ECPs for their care will have less access to the care they need.

AMCHP appreciates the opportunity to comment on the proposed rule. If we can provide any additional information, please contact Amy Haddad, Director of Policy and Government Affairs, at 202-266-3045.

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10 See Peña Et. Al., supra, note 51 at 2-3.