



November 27, 2017

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Attention: CMS-9930-P

Submitted electronically

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

Dear Administrator Verma:

On behalf of the nearly 4,800 members of the Private Practice Section (PPS) of the 100,000 member American Physical Therapy Association (APTA), I write to comment on the Centers for Medicare and Medicaid Services (CMS) Proposed Rule regarding “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019” (CMS-9930-P), published in the November 2, 2017 *Federal Register*.

We have significant concerns with the proposed rule as currently drafted. The proposed changes to the health insurance marketplace, if adopted, would likely have a detrimental impact on the practice of physical therapy, but also patients’ ability to access medically necessary care. As CMS works to implement the policies proposed in this rule, as healthcare professionals who provide care included in current list of the Essential Health Benefits (EHB) categories, PPS strongly urges the Agency to consider the following recommendations that are relevant to our membership:

Recommendations

- PPS strongly opposes CMS’ proposal to alter the current process by which states choose an EHB-benchmark plan and thereby recommends that CMS not pursue its proposed changes.
- To protect consumers and avoid significant market disruption, PPS strongly recommends that CMS not permit states to select a new EHB-benchmark plan on an annual basis.
- Should CMS move forward with its proposal to provide states additional flexibility in how they select their EHB-benchmark plans, PPS recommends that CMS define a typical employer plan as a plan that covers all 10 EHB categories and excludes self-insured

plans. Additionally, PPS urges CMS to require the utilization of a single standardized notice and public comment process when a state proposes to change its EHB-benchmark plan.

- PPS strongly urges CMS not to codify the proposed changes to the navigator program because eliminating this valuable consumer assistance tool will harm patients' ability to make well-informed decisions regarding their coverage and health care.

Flexibility for States to Update Their EHB-Benchmark Plans

CMS has proposed a state may select a new EHB-benchmark plan on an annual basis. CMS also has proposed to give states additional flexibility in how they select their EHB-benchmark plan by offering states more options in what they may define as a qualifying EHB-benchmark plan.

In addition to the options currently afforded to states, states would also be allowed to:

1. Select the EHB-benchmark plan that another state used for the 2017 plan year;
2. Replace one or more EHB categories of benefits in the state's EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or
3. Select a set of benefits that would become the state's EHB-benchmark plan, provided that the EHB-benchmark plan does not exceed the generosity of the most generous of among a set of comparison plans, including the state's EHB-benchmark plan used for the 2017 plan year and any of the state's base benchmark plan options for the 2017 year. This plan must also be equal in scope of benefits to what is provided under a typical employer plan.

PPS Comment:

PPS has significant concerns with CMS's proposal to offer states substantially more flexibility in the manner by which they can select an EHB-benchmark plan and allowing them to do so on an annual basis. By CMS's own admission within the proposed rule, consumers who have specific health needs may be negatively impacted by the proposed rule. Depending on the EHB-benchmark selection made by the state in which the consumer lives, patients may wind up with a less comprehensive plan, resulting in the loss of coverage for services.

Giving states more flexibility will place many patients at risk of losing access to medically necessary services that should be covered. Private practice physical therapists meet the clinical needs of a broad spectrum of patients with varying severity and intensity of impairments. It is imperative that all individuals have access to high quality providers across the care continuum. Eroding the current EHB runs the risk of a state choosing a plan with lower standards without a thorough analysis of how that plan will impact its residents.

While the Patient Protection and Affordable Care Act (ACA) explicitly requires coverage of habilitative and rehabilitative services, PPS has significant concerns that CMS's proposal could result in limited access to critical aspects of healthcare, including habilitative and rehabilitative services. As a healthcare provider whose patients are likely to be impacted by the proposed changes, PPS urges CMS not to move forward with its proposal to offer states greater latitude in their selection of an EHB-benchmark plan, particularly its proposal to provide authority to states to develop their own EHB-benchmark plan.

Allowing States to Update Their Benchmark Plans Annually

PPS has serious concerns with CMS's proposal to allow states to select a new EHB-benchmark plan on an annual basis. Allowing a state to update an EHB-benchmark plan annually would impose a significant financial and administrative burden on consumers, healthcare providers, employers, and plan issuers by requiring them to understand and maintain compliance with the EHBs that must be covered by plans. CMS's proposal also would cause significant market disruption and mass confusion, as updating a benchmark plan each year will require each health insurance issuer to update the plans they offer. In turn, consumers, who already experience significant challenges selecting a plan, will be faced with ever-changing benefits and costs which could result in an increase in consumer errors in the selection of a plan.

Definition of Typical Employer Plan

Only those plans that already cover all 10 EHB categories should be eligible to be considered a typical employer plan. Furthermore, PPS strongly recommends that CMS exclude self-insured plans from the definition of typical employer plan, as these plans are exempt from state insurance laws and often are atypical in their coverage of services and are therefore not relevant to this discussion. The selection of a new EHB-benchmark plan must be done in an open, transparent, meaningful manner that ensures consumers, providers, and employers have a sufficient understanding of the criteria considered by a state in selecting an EHB-benchmark plan.

Reasonable Notice and Public Comment Period

CMS proposes to codify reasonable notice and public comment requirements that would apply any time a state changed its EHB-benchmark plan, but does not otherwise propose a standardized process or specific requirement.

PPS Comment:

Private Practice physical therapists are both providers and consumers of healthcare services. Our members have the right to be an active participant in rulemaking on regulations that may affect me. In order to ensure that right is accessible, there must be a standard process for state rulemaking on the selection of EHB-benchmark plans. The consideration of public comments will be very important in helping a state understand how the proposed EHB-benchmark plan may affect its residents and the potential unintended consequences. As such, it is imperative that there be one standardized process, rather than 50 different notice and public comment requirements in order to ensure all consumers are afforded an equal opportunity to provide feedback to their states on a proposed EHB-benchmark plan. PPS strongly encourages CMS to require a single standardized process to change or adopt an EHB-benchmark plan. This standardized process should include: 1) posting of the notice on the state's website; 2) a comment period of at least 60 days; and 3) the ability to submit comments online, in-person, via mail, or by fax.

Navigator Program

CMS proposes to remove the current requirement that each exchange have at least 2 navigator entities and that one of these entities be a community and consumer-focused nonprofit group. Additionally, the Agency proposes to eliminate the requirement that navigators maintain a physical presence in the exchange service area to provide in-person outreach and enrollment support.

PPS Comment:

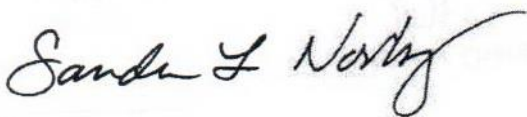
PPS strongly opposes CMS' proposal and recommend that the Agency not move forward with its proposed changes to the Navigator program. The Navigator program is a consumer assistance tool that consumers utilize and need in order to make well-informed decisions regarding their coverage and healthcare. Well-informed consumers who have access to open, up-front communications about coverage, expected out-of-pocket expenses, and quality ratings are better positioned to understanding a plan's benefits and costs and therefore choose an insurance plan that meets their needs. The proposal to scale back the navigator program effectively erodes CMS' move towards patient-centered healthcare. Without a robust Navigator program, consumers run the risk of selecting options that are not cost-efficient and inappropriate for themselves and their families.

PPS strongly urges the Agency to consider the detrimental impact its Navigator program proposals would have on consumers. Rather than stripping away marketplace assistance tools for consumers, PPS encourages the Agency to enhance the breadth and scope of the Navigator program. This would help to ensure consumers, small businesses, and their employees have access to the necessary assistance to help them adequately review and understand their health coverage options, as well as complete eligibility and enrollment forms.

Conclusion

PPS appreciates the opportunity to share our insights and perspective with CMS on the CY 2019 Notice of Benefit and Payment Parameters proposed rule. PPS strongly recommends that CMS reverse course and not grant states additional flexibility to update their EHB-benchmark plans as currently proposed. Moreover, we recommend that CMS maintain the current Navigator program to ensure consumers have adequate tools to make well-informed decisions regarding their health care. We look forward to more opportunities to partner with CMS in pursuit of meaningful and effective regulations to ensure patient-centered care.

Sincerely,

A handwritten signature in cursive script that reads "Sandra L. Norby". The signature is written in black ink and is positioned above the typed name and title.

Sandra Norby, PT, DPT
President, Private Practice Section of APTA