American Kidney Fund®

November 27, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS–9930–P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019

Dear Administrator Verma:

The American Kidney Fund (AKF) appreciates the opportunity to provide comments on the proposed rule regarding the "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019."

The American Kidney Fund is the nation's leading independent nonprofit organization working on behalf of the 30 million Americans with kidney disease. For the past half-century, AKF has existed to help people fight kidney disease and live healthier lives. We provide a complete spectrum of programs and services: top-rated education materials; free kidney disease screenings in numerous cities across the nation; clinical research funding; and need-based financial assistance enabling one in five U.S. dialysis patients to access lifesaving medical care, including dialysis and transplantation.

AKF is also a member of Kidney Care Partners (KCP), an alliance of members of the kidney care community. In addition to our comments below, we support the comments that KCP has submitted.

Essential Health Benefits Package (§156.100, §156.110, §156.111 and §156.115)

AKF appreciates CMS's aim to provide states additional flexibility that would encourage more innovation in health insurance product design and more affordable plan options for consumers. However, we believe it is imperative that CMS also ensure patient protections, especially for people with chronic conditions such as kidney disease, so that individuals have access to the services they need to manage their conditions. Therefore, we have significant concerns with the proposed changes to states' selection of essential health

benefits (EHB) benchmark plans and the rules regarding EHB substitution. We believe they would potentially weaken the level of meaningful health coverage available to individuals with a chronic disease.

Current regulations already grant states a good deal of flexibility in selecting their EHB-benchmark plan, as they have 10 specified plan options to choose from. That flexibility is balanced with the statutory requirement that the scope of EHB coverage is equal to the scope of benefits provided under a typical employer plan. CMS is proposing to give states greater flexibility by allowing them to change their EHB-benchmark plan on an annual basis and by giving them the following additional options in selecting their benchmark: adopt another state's 2017 EHB-benchmark plan; replace one or more EHB categories with those of another state's 2017 EHB-benchmark plan categories; or create a new EHB-benchmark plan, provided that it does not exceed the generosity of the most generous of a set of comparison plans. CMS is also proposing to define a typical employer plan as either a small-group, large-group, or self-insured group plan with at least 5,000 enrollees in one or more states.

We oppose the breadth of the proposed changes to states' selection of EHB-benchmark plans because they could lead to the creation of benchmark plans that are a patchwork of the least comprehensive categories of coverage. And because the proposed definition of "typical employer plan" could include a plan that has a narrow set of benefits but has 5,000 enrollees, EHB-benchmark plans that exclude certain services for chronic diseases would still be in compliance with the scope of benefits requirement. We are concerned that, taken together in their entirety, the proposed changes to EHB-benchmark plans could jeopardize access to life-saving services and treatments such as chronic kidney disease management, dialysis treatment, and kidney transplant. The changes could also result in higher out-of-pocket costs for people living with a chronic disease, as the out-of-pocket maximum and prohibitions on annual and lifetime dollar limits only apply to services under the EHB.

Similarly, we oppose CMS's proposal to allow states to permit issuers to substitute services between EHB categories because of our concern that it could lead to inadequate coverage of critical services for chronic conditions. People with costly chronic diseases, such as kidney failure, could see cuts or substitutions in their benefit coverage that could limit or exclude services that are vital to their care.

We recognize CMS's desire to provide additional state flexibility in implementing PPACA. As CMS notes, the intention of the EHB proposal "is to provide flexibility and the option for stability" for states by allowing them to change their EHB-benchmark annually or to maintain their current benchmark without action. However, AKF is concerned the proposed changes in the EHB package could compromise the stability of comprehensive coverage for patients. An individual could find that a needed service is suddenly no longer covered in their plan as an EHB because their state decided to change their EHB-benchmark from the previous year, resulting in greater out-of-pocket costs for the individual. We strongly recommend that CMS not finalize the EHB provisions

as proposed, and continue to work with stakeholders to develop other possible ideas that balance state flexibility while ensuring access to essential health services for individuals.

Thank you for your consideration of AKF's comments and recommendations.

Sincerely,

LaVarne A. Burton
President and CEO