

November 27, 2017  
The Honorable Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-9930-P  
200 Independence Avenue, SW  
Washington, DC 20201

Re: Comments on HHS Notice of Benefit and Payment Parameters for 2019 Proposed Rule, RIN 0938-AT12

Dear Administrator Verma:

On behalf of the Endocrine Society, we are pleased to offer comments on the proposed rule, *Notice of Benefit and Payment Parameters for 2019*. Founded in 1916, the Society represents more than 18,000 physicians and scientists in the field of endocrinology. Our physicians and scientists are engaged in the treatment and research of endocrine disorders, including diabetes, thyroid disease, obesity, infertility, growth disorders, sleep disorders, and endocrine cancers.

The Affordable Care Act (ACA) provided many critical patient protections, including the elimination of lifetime and annual caps and the limit on out-of-pocket costs that have improved access to coverage and care for many of the patients that our members treat. We are pleased that the Centers for Medicare and Medicaid Services (CMS) has maintained these patient protections, but we are extremely concerned that the proposed changes in this rule related to the essential health benefits (EHBs) will undermine these protections making the plan options available in the individual market less comprehensive. For patients with chronic, high-cost conditions, these changes could be devastating.

The ACA required that all health insurance plans sold in the individual market cover the 10 EHBs, including hospitalizations, prescription drugs, preventive and wellness services and chronic disease management, and emergency services. It also required that plans be equal in scope to a typical employer plan, have an appropriate balance across all categories, and prohibit plan benefit design from discriminating based on an individual's age or disability. The EHBs must also consider the health needs of diverse segments of the population including women, children, persons with disabilities, and other groups.

We are concerned that allowing states to establish their own set of covered EHBs will increase premiums for people with pre-existing conditions, re-introduce annual and lifetime caps, or force people to purchase bare-bone plans because that is all they are able to afford. These EHBs were



established to ensure that all enrollees had access to basic health care services that are vital to prevent diseases and manage conditions that already exist to prevent further complications.

States currently have 10 benchmark plans, 7 of which are state-specific with the other three being Federal Employees Health Benefits Program (FEHBP) plans, that can be used to define its EHB package that meets the needs of the state. CMS has proposed to revise this policy to provide states with greater flexibility, allowing states to select benchmark plans from other states or benefit categories from another state's benchmark plans.

If finalized, these changes will dilute the coverage and patient protections available in the states that exercise these options. States will be discouraged from offering plans with coverage more comprehensive than that of the benchmark plan because they will be responsible for the costs beyond the minimum benefits. Ultimately, these costs will be passed on to patients through increased cost sharing and out-of-pocket expenses. While it is unclear how many states would set their benchmarks with less comprehensive EHBs, CMS estimates that 10 states would choose to change their EHB-benchmarks in each year and has acknowledged it is more likely that the changes the states will make will reduce benefits and premiums, rather than expanding them. For patients with endocrine disorders, care could become unaffordable. We urge CMS not to finalize this policy as proposed and retain the current policy that governs how states define and select their benchmark plans.

Furthermore, by proposing to redefine "typical employer" as any plan with 5,000 enrollees, states would be able to select EHBs from self-insured plans that frequently have fewer enrollees. These plans tend to have less generous benefits than those offered by large groups. Any dilution of the EHBs that results from this revised definition will undermine the ACA's patient protections, moving the individual market closer to how it operated before the passage of the ACA. The Society urges you not to finalize this revised definition of "typical employer."

We appreciate the opportunity to provide comments on this proposed rule. Please contact Mila Becker, Chief Policy Officer, at [mbecker@endocrine.org](mailto:mbecker@endocrine.org) if we can provide any additional information or assistance as CMS considers these comments and develops its final policy.

Sincerely,

Barbara Byrd Keenan  
Chief Executive Officer  
Endocrine Society