December 21, 2015

Disability Rights Education & Defense Fund

Andrew Slavitt
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9937-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-9937-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 (RIN 0938–AS57)

Dear Administrator Slavitt:

Disability Rights Education and Defense Fund (DREDF) appreciates the opportunity to provide comment on the proposed HHS Notice of Benefit and Payment Parameters that proposes key standards for issuers and Health Insurance Marketplaces for 2017. As an organization founded by people with disabilities and parents of children with disabilities, we affirm how much people with disabilities of all ages and income levels need effective, accessible healthcare in their communities.

Many adults with disabilities need the flexibility that can come with working less than full-time, as consultants, and/or with smaller or non-profit organizations who seek insurance through the Small Business Health Options Program (SHOP). Marketplace insurance is critical to these individuals, as well as individuals with disabilities who work episodically or who have a fluctuating income flow, and therefore may be subject to insurance churn between Marketplace and Medicaid eligibility. Marketplace insurance that is comprehensive, affordable, high quality, and transparent will support individuals with disabilities and their families to lead independent, productive and fully integrated lives in their communities. Our comments below are intended to support the Centers for Medicare and Medicaid Services (CMS) in developing and proposing benefit and payment parameter standards that will recognize the healthcare coverage needs of people with disabilities and their families, and reduce such systemic barriers as physically and programmatically inaccessible plan provider networks.

Our first overarching comment pertains to the truncated comment period attached to this proposed rule. We do note that the proposed rule was released immediately before the Thanksgiving break and only formally published on December 2. The comments are due a scant three weeks later on December 21, 2015. Gathering the experiences of consumers with disabilities in the Marketplaces, and sufficiently analyzing those experiences in a way that will pinpoint particular problems and patterns among issuers so that we can write helpful comments, is challenging enough with longer comment periods. We respectfully request that CMS considers providing additional time, in future, for submitting comments on proposed rules for issuer standards. It has been difficult to address all aspects of the proposed rule in our comment, and we have been...
unable to address, for example, what the proposed rule has to say about the medical loss ratio program.

**Essential Health Benefits**

DREDF appreciates CMS' clarification in last year's final rule of the rehabilitative and habilitative services and devices category of essential health benefits (EHBs) and the establishment of a federal minimum definition of coverage. It would be very helpful for CMS, in this year's proposed rule, to elaborate further on this particular benefit category in light of new or continued benefit restrictions that consumers with disabilities are encountering. Many QHP’s have instituted arbitrary caps in certain rehabilitative and habilitative health benefits, such as one-size-fits-all outpatient therapy caps. In California, small businesses are encountering plans in all metal ranges that either have an outright benefit coverage cap of approximately $2000 on Durable Medical Equipment (DME) such as wheelchairs, or haphazardly divide rehabilitative/habilitative devices into ‘DME” and “Supplementary DME” categories; supplementary DME includes items such as wheelchairs, hospital beds, and some ventilators and are simply not covered under the plan at all.

DREDF requests CMS to include in the final rule a strong admonition to QHPs that these types of arbitrary restrictions and caps in habilitation and rehabilitation benefits are not consistent with patient-centered care or, more importantly, the non-discrimination requirements under the ACA for plan design under both Sections 1302 and 1557. If states allow issuers to impose monetary or quantitative caps in rehabilitation or habilitation therapy services and devices that are based on explicit or implicit disability-based distinctions, they must be must be justified by legitimate actuarial data or actual or reasonably anticipated experience, and not the mere fact that the restriction or cap has been imposed historically. In addition, there must be an exceptions process to meet the needs of individuals who simply require more therapy than the cap allows for the person with average therapy needs, or for individuals who require medically-necessary DME items that issuers attempt to exclude from coverage or subject to limited coverage. Imposing caps on coverage can easily serve as de-facto annual monetary caps on coverage, which violate ACA requirements. DME benefit limitations are actual monetary caps, whatever they bear a historical or new name.

Examples of discriminatory caps, and discriminatory QHP EHB designs more broadly, include plan provisions that:

- Place limits on the number of therapy visits a QHP enrollee can access regardless of whether the enrollee meets medical necessity criteria;
- Place monetary or quantitative coverage limits on medically necessary DME or other rehabilitative or habilitative devices available to QHP enrollees;
- Apply a benefit exclusion for certain types of modern prosthetic limb to only one disability group, individuals with limb loss; and,
- Fail to cover brain injury services in their EHB when the enrollee's brain injury is related to a suicide attempt.
Network Adequacy

We commend CMS for moving forward on establishing specific network adequacy standards for qualified health plans (QHPs) in the Federally Facilitated Exchanges (FFE) and that regulators, either the state or the FFE, would be responsible for prospectively applying the standards to the QHPs. This is an important step forward in strengthening provider networks and ensuring that all enrollees have access to the services promised to them through the health plan. We strongly encourage CMS to require all states, not just those with FFEs, to adopt specific network adequacy standards.

We continue to be concerned that the new standards in the proposed rule will not ensure that QHP provider networks have a sufficient range of specialists with the training and expertise to provide appropriate, high-quality and cost-effective care for children and adults with disabilities and chronic conditions. In addition, DREDF is remains deeply concerned that that the new standards to not address the need for physical and programmatic accessibility of QHP provider networks. To this end, we recommend that CMS incorporate additional language that has been adopted in the NAIC Network Adequacy Model Act that states the following:

(3) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider when:

(a) The covered person is diagnosed with a condition or disease that requires specialized health care services or medical services; and

(b) The health carrier:
   (i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or
   (ii) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(For purposes of this paragraph, “specialized health care services or medical services” include the delivery of covered benefits in a manner that is physically accessible and provides communication and accommodations needed by covered persons with disabilities.)

DREDF’s full position, in fact, is that network adequacy standards should outright incorporate requirements for physically and programmatic accessibility of provider networks within network adequacy standards. That is, if a state chooses to adopt time and distance standards, those standards need to explicitly require a choice of physically and programmatic accessibility of provider offices available to enrollees with disabilities, as well as established policies and procedures that will apply where those standards are not met, such as out-of-network referrals or transportation to providers that lie outside of
the usual time/distance standards. In the absence of such an explicit incorporation of physical and programmatically accessible standards, then a requirement for out-of-network coverage of physically and programmatically accessible providers at least gives QHPs an excellent incentive to improve and maintain physical and programmatic accessibility within their existing networks, including when there is any tiering within those networks.

In the Proposed Rule, each QHP must either: 1) count cost-sharing paid by an enrollee for an EHB service provided by an out-of-network provider in an in-network setting toward the enrollee’s annual limitation on cost sharing, or 2) provide a written notice to the enrollee at least 10 business days before the service is to be provided, alerting the enrollee to possible added costs, including balance billing charges, incurred for such a situation and that such charges may not count toward the in-network annual cost sharing limit.

When an individual must use an out-of-network provider because there is no provider available in-network that is capable of providing a covered benefit, or no provider that is physically or programmatically accessible to the individual that also meets applicable network adequacy standards, that person must not be penalized by the health plan. For example, cost-sharing and other requirements for the receipt of out-of-network care should follow the same protections set forth by the plan as if the care was contracted as in-network. Plans should demonstrate that they maintain an adequate and timely approval process for out-of-network services, utilize appropriate clinical standards in evaluating requests, and have a clear, transparent, and timely appeals process for denied services.

DREDF also proposes that CMS prohibit additional out-of-pocket costs to consumers who are referred out of network for disability-related access reasons. This will also provide a strong and needed incentive to QHPs to build physically and programmatically accessible provider networks that are adequate to meet the treatment and benefit needs of their enrollees with disabilities. If that recommendation is too problematic for this year’s proposed rule, then at the very least, we recommend that §156.230(e)(2) be revised to make it clear that consumer cost-sharing paid to a provider under this provision also counts toward the maximum out-of-pocket (MOOP) limit and that consumers not be subject to balance billing. This is necessary to ensure that consumers are held harmless when they lose access to a provider partway through their plan year, when they have no ability to switch to a different plan.

Continuity of Care

Sadly, there are circumstances that will place an individual at risk of not being able to obtain care if a plan becomes insolvent or engages in other transactions that impact patient care. It is especially important that a person’s care not be disrupted as the result of provider network or corporate change. Without strong delineated continuity of care protections, fragmented care can threaten the health and well-being of the individual or result in exorbitant out-of-pocket costs through out-of-network cost sharing rates.
HHS has proposed that if a patient is in active treatment and a provider is terminated from the network without cause, the patient can continue treatment with that provider for up to 90 days. We would also recommend that continuity of care protections should extend to transition prescription fills when switching to a new health plan and that HHS require, not simply urge, that plans provide 30-day transition fills for off-formulary medicines or those under utilization management. Finally, we recommend that in the case of critical providers such as wheelchair seating providers who serve consumers with complex rehabilitation needs, the enrollee should be able to continue working with that provider for the life of the equipment, including coverage for repairs and custom seat fittings.

Payments Made to QHPs by Third Parties on Behalf of QHP Enrollees

We support the ability of third-party entities, including federal and state government and Indian tribes, to contribute to patient premiums and cost-sharing. To have this ability increases access to health care for individuals in need of services and treatments, including prescription medications, who may not otherwise be able to afford them. We appreciate HHS efforts to clarify the programs that would meet the definition of state and government programs to be more inclusive and include subdivisions and local governments. We also support that third party payments can be made by these government’s grantees or sub-grantees. Finally, we strongly support the inclusion of not-for-profit, charitable organizations as entities that would be allowed to make payments for premiums and cost-sharing.

Proposed Standardized Benefits Option (SBO)

DREDF supports the intent to simplify the experience of shopping for a qualified health plan (QHP) through standardized benefit options. However, we do believe there is a need for caution. “Standardization” should not be taken by QHPs as an opportunity to provide benefit packages that consistently fail to serve the treatment and equipment needs of lower-incidence disabilities. For example, in the standardization process, if there are groups of benefits that are less than adequate, such as benefits for children or visits to physical, occupational or speech therapy or hearing services, we must be careful not to “freeze” them in place as a standard across numerous plans.

There is also an advantage in having a clear picture of cost sharing so consumers can make educated choices. However, there is concern about the use of a “specialty drug” tier, which is not clearly defined and has grown in cost over recent years. The number of pharmaceuticals that are placed on the specialty tier, by insurers, for treatment of serious and chronic conditions has multiplied and the criteria for this choice remains obscure.

We strongly support the premise that prescription medications should not be subject to a plan’s deductible. If medications are included in the deductible, it is likely that individuals will not be able to afford the potentially high cost of paying the deductible before support is available for the early prescriptions in the year. It is our understanding that in most of the various metal levels and proposed tiers, patients’ cost sharing for prescription medications are not subject to the deductible. We are concerned that the
cost-sharing for medications in the bronze plans, except for generic drugs, would be subject to the plan’s deductible.

We also support the exemption of additional services from the deductible, including primary care and specialty visits, and we would like to urge HHS to add habilitative services to the list rather than limiting the exemption to rehabilitative services. Particularly for children with disabilities and chronic illnesses, coverage of habilitative services is critical. For those who may have a condition at birth, such as cerebral palsy, spina bifida or autism, or have experienced an illness or injury that prevents normal skills development and functioning (such as a brain injury), habilitative services should be available early and consistently for the best and most cost-effective outcome.

Cost sharing is a primary factor in the choosing of a QHP. The increased use of coinsurance is concerning because it provides no transparency and makes it hard to determine what a plan may actually cost as different products are considered. In the SBO discussion, the use of coinsurance for the specialty tier on the Bronze, Silver and Gold plans, ranging from 25 percent to 50 percent, makes it very hard to know what the costs may be when choosing a plan and then, perhaps to actually be able to pay them.

Protecting Access to Prescription Drugs

In the proposed rule, HHS is soliciting comments on future changes under consideration for the formulary exceptions process. There is an effort in the proposed rule to clarify the formulary exceptions process for Essential Health Benefits (EHB) and we are in support of strong federal protections being available and not relying on what may be weaker state protections. Currently, plans are required to have a process in place for considering requests in a timely manner when individuals seek access to non-formulary drugs. If the exception is granted, the costs for the non-formulary drug count toward the annual out-of-pocket cost limit.

HHS is considering a change that would deem a plan to be in compliance with the rule if the plan follows state provisions that are either “more stringent than or in conflict with” the federal standard. We want to take this opportunity to support strong federal protections as a floor and would not oppose application of more stringent state regulation, but we would be concerned about apply state regulations that are merely “in conflict with” the federal regulations. It would be our position that the federal oversight authorities should determine if a state regulation is adequate, in conflict or congruent with federal regulation on formulary exceptions.

State Mandates and Essential Health Benefits

DREDF would like to request more clarification and guidance from HHS on the interaction of state mandates and essential health benefits. Without further direction, we are concerned that states will delay or reverse mandating coverage to ensure that people with disabilities have access to medically necessary treatments. If all states EHB packages covered medically necessary treatment for autism spectrum disorders, states would not have to defray the cost of any mandated benefits.
Discriminatory Plan Design

We want to take this opportunity to encourage HHS and state insurance authorities to review plans for discriminatory plan design and take action against those plans that are engaging in practices that harm patients, particularly those with disabilities or chronic conditions. It is the now the role of HHS and the Office of Civil Rights to properly enforce the law to ensure beneficiary rights are protected.

Thank you again for the opportunity to comment on the proposed rule. Please do not hesitate to contact us if there are any questions about the above.

Yours Truly,

Silvia Yee
Senior Staff Attorney