

Disability Rights Education & Defense

Fund



November 27, 2017

Via Electronic Submission (www.regulations.gov)

Ms. Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-9930-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-9930-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019 (RIN 0938-AT12)

Dear Administrator Verma:

The Disability Rights Education and Defense Fund (“DREDF”) appreciates the opportunity to provide comment on the proposed HHS Notice of Benefit and Payment Parameters for 2019. DREDF is a national cross-disability law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. We are committed to increasing accessible and equally effective healthcare for people with disabilities and eliminating persistent health disparities that affect the length and quality of their lives.

Our first overarching comment pertains to the truncated comment period attached to this proposed rule. We note that the proposed rule was only formally published on November 2, 2017, with the comments due a scant three weeks later on November 27—the Monday after the Thanksgiving break. Gathering the experiences of consumers with disabilities in the individual and small group markets and sufficiently analyzing those experiences so that we can write helpful comments is challenging enough with longer comment periods. We respectfully request that CMS provide additional time in the future for submitting comments on proposed rules, consistent with the Administrative Procedures Act. It has been difficult to address all aspects of the proposed rule, even prioritizing those with significant implication for people with disabilities, in our comment with the time provided.

We also submit the following comments relating to the substance of the proposed rule.

I. Essential Health Benefits

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DREDF emphasizes the critical importance of health insurance issuers providing comprehensive coverage of essential health benefits (“EHBs”) in the individual and small group markets. For many individuals with disabilities, the adequate provision of EHBs is fundamental to maintaining health and function. In particular, the statutory EHB categories of rehabilitative and habilitative services and devices, prescription drugs, and mental health coverage provide items and services that enable people with chronic conditions and disabilities to function independently, pursue education and employment, and contribute to their communities.

For example, durable medical equipment¹ such as a wheelchair is typically encompassed within the rehabilitative and habilitative services and devices EHB category.² For people with mobility disabilities, access to a working and properly fitted wheelchair can be a gateway to full participation in their communities. Without health insurance coverage of appropriate equipment, people are often homebound—unable to work, go to school, or even get out of bed. Others may be forced to obtain lesser devices than what they medically need, putting their health and safety at risk. Still others face institutionalization because they cannot function in their own homes.

For illustration, consider Sophia’s story.³ Sophia is a 58-year-old woman who works at a community-based nonprofit organization. She has cerebral palsy and needs a power wheelchair to move around her home, go to work, run errands, and otherwise live a full life in her community. Sophia’s wheelchair is now six years old and malfunctioning. Despite paying a high premium each month for Platinum-tier coverage, her small group plan will not cover her medically necessary wheelchair repairs. As a temporary fix, she was forced to go to the hardware store, saw off part of her wheelchair, and secure it with wire tires. Sophia’s health and safety continues to be at risk each time she uses her chair.

It is with these prospects in mind—a reality today for many in the disability community—that we highlight the following concerns with HHS’ proposed revisions to the EHB rules.

A. Benchmark Standards (Proposed § 156.111)

DREDF strongly opposes HHS’ proposal to expand States’ EHB-benchmark plan options for plan years beginning on or after January 1, 2019. The new approach would allow States to change their benchmark plan annually by either selecting another State’s 2017 benchmark plan; substituting one or more EHB categories from another State’s 2017 benchmark plan; or selecting a new benchmark plan that is equal in scope to a typical employer plan and is no more generous than the most generous comparison

¹ Durable Medical Equipment (“DME”) encompasses a variety of devices intended for ongoing use such as ventilators, crutches, wheelchairs, patient lifts, hospital beds, shower chairs, infusion pumps, and blood glucose monitors that help with such basic functions as breathing, mobility, using the restroom, and monitoring one’s health.

² Rehabilitative and habilitative services and devices are health care services and devices that help a person “attain, [] regain, maintain, or prevent deterioration of a skill or function” that was either “never learned or acquired due to a disabling condition” or “lost or impaired due to illness, injury, or disabling condition.” HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,811 (Feb. 17, 2015).

³ Sophia’s name has been changed for privacy reasons.

plan. This expansive approach would fundamentally violate the ACA's EHB and nondiscrimination provisions, leaving people with disabilities with inadequate access to essential health services and devices.

i. The New Benchmark Approach Would Impermissibly Delegate Authority to the States

DREDF is concerned that the new benchmark approach would impermissibly delegate to the States the authority to define EHBs, in plain violation of the ACA and well-established administrative law.⁴ Section 1302(b)(1) of the ACA directs: “the *Secretary* shall define the essential health benefits . . . ” (emphasis added). Caselaw is clear that a power vested in an executive agency may not be sub-delegated to the States, plans, or any other external entity.⁵

The current EHB regulations give the States a constrained directive on selecting benchmark standards in the individual and small group markets.⁶ The proposed rule would vastly and impermissibly expand deference to the State's selection—even allowing the State to design its own set of benefits that would become the benchmark plan. The only true limit on this flexibility is that the benchmark must be equal in scope of benefits to “a typical employer plan.” However, by defining typicality to include plans with as little as 5,000 enrollees, the agency will render this limit effectively null—as States will be permitted to consider small, outlier plans as “typical.”⁷ DREDF is concerned that this expansive form of “flexibility” is inappropriate for HHS to delegate and may face judicial challenges under fundamental principles of administrative law, increasing uncertainty for insurers, and most importantly for our purposes, individuals and families with disabilities.

ii. The New Benchmark Approach Would Violate The ACA's Categorical EHB Mandates

DREDF is also concerned that the new benchmark approach would impermissibly allow States to sidestep the ACA's categorical EHB mandates. Section 1302(b)(1) of the ACA provides: “the Secretary shall define the essential health benefits, *except that* such benefits shall include at least the [ten enumerated] categories *and the items and services covered within the categories*” (emphasis added).

Here, by allowing States to substitute entire categories of EHBs in their benchmark plans and also by allowing States to wholly define the content of the benchmark and its EHB categories,⁸ the agency is impermissibly encouraging States to actually *exclude* “items and services covered within the [EHB] categories” in the name of “flexibility.” Indeed, the agency explicitly recognizes this reality on Page 290 of the proposed rule: “Consumers who have specific health needs may also be impacted by the proposed

⁴ See, e.g., U.S. Telecomm. Ass'n v. Fed. Comm'n Comm'n, 359 F.3d 554 (D.D.C. 2004).

⁵ *Id.*

⁶ See 45 C.F.R. § 156.100(a)(1) (2016).

⁷ See *infra* Section I.B. for DREDF's further comments on the definition of “typical employer plan.”

⁸ Provided it is equal in scope of benefits to a “typical employer plan,” defined expansively to mean plans with at least 5,000 enrollees.

policy. In the individual and small group markets . . . consumers with less comprehensive plans may no longer have coverage for certain services.” DREDF is concerned that this approach will violate the ACA’s categorical EHB provisions designed to protect against such inadequate coverage and result in a discriminatory impact against people with disabilities, many of whom have complex health needs and rely on health services and supports for daily functioning. In particular, those individuals with disabilities who have rarer conditions or a combination of primary and secondary conditions may have a set of medically necessary healthcare needs that literally forces them to choose among, for example, coverage of prescription drugs, therapies, and mental health treatment.

iii. The New Benchmark Approach Would Render Illusory The ACA’s Prohibition on Lifetime and Annual Dollar Limits

Section 2711 of the ACA prohibits individual and group health plans from placing “lifetime” or “annual limits on the dollar value of [essential health] benefits for any participant or beneficiary.” DREDF is concerned that HHS’ proposal will permit lifetime and annual limits on EHBs to continue as integrated components of the State’s benchmark plan, rendering this statutory provision illusory.

For illustration, consider the treatment of durable medical equipment (“DME”) in California’s 2017 small group benchmark plan. The benchmark plan purports to cover DME as an EHB within the rehabilitative and habilitative services and devices category.⁹ However, it draws an arbitrary distinction between “Base” and “Supplemental” DME.¹⁰ Base DME is defined to include low cost items, such as blood glucose monitors, canes, crutches, and IV poles; Supplemental DME is defined to include more costly devices such as wheelchairs, CPAP machines, and hospital beds.¹¹ The benchmark treats Base DME as an EHB and covers it without a dollar limits, but it claims Supplemental DME is not an EHB—meaning that plans can and do either completely exclude coverage of items like wheelchairs or impose \$2,000 annual dollar limits on them.¹² This means that people needing a wheelchair—the quintessential “rehabilitative and habilitative device” by any measure—still face annual limits on (or outright exclusions of) EHBs, despite Congress’ explicit intent to achieve the opposite result¹³ and regardless of an undisputed medical necessity for the device in question.

⁹ See CAL. HEALTH & SAFETY CODE § 1367.005(a)(2)(a) (2016) (selecting the Kaiser Foundation Health Plan Small Group HMO 30 plan as the State’s 2017 benchmark plan); CTRS. FOR MEDICARE & MEDICAID SERVS., *California EHB Benchmark Plan*, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/california-ehb-benchmark-plan.pdf>.

¹⁰ KAISER PERMANENTE, *2017 Durable Medical Equipment (DME) Benefits*, https://account.kp.org/static/bcssp/pdfs/shared/cal/2017/KP_CA_SB_DME_Benefits_Flyer_2017.pdf (detailing Kaiser’s policy on coverage of durable medical equipment in all small group plans).

¹¹ *Id.*

¹² As a point of reference, wheelchairs can cost up to \$25,000 out-of-pocket.

¹³ See, e.g., 111 CONG. REC. 1882 (March 21, 2010) (statement of Congressman George Miller, Chairman of the House Education and Labor Committee) (emphasizing the importance of rehabilitative and habilitative devices to people with disabilities and chronic conditions and expressing his clear understanding that such devices “include[] durable medical equipment, prosthetics, orthotics, and related supplies”).

This one example is undoubtedly replicated across all ten EHB categories, within dozens of plan products, and among all fifty states. The new benchmark approach will only exacerbate these deceptive and discriminatory coverage practices, leaving people with disabilities without the tools they need to equally participate in and contribute to society.

iv. The New Benchmark Approach Would Violate the ACA's Nondiscrimination Provisions

DREDF is concerned that the new benchmark approach would permit and encourage States to seek out benchmark plan designs that offer discriminatory benefit limits and scopes of coverage, in violation of the ACA's numerous nondiscrimination mandates.

First, Section 1557 of the ACA and its implementing regulations prohibit discrimination on the basis of disability, age, sex, gender identity, race, color, or national origin in all health programs and activities receiving federal financial assistance.¹⁴ Discrimination includes the creation or implementation of benefit designs that have a discriminatory impact on a protected class;¹⁵ “benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs;”¹⁶ and benefit designs that otherwise discriminate on the basis of “expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.”¹⁷ The new benchmark approach will give States so much “flexibility” that they will be permitted to maintain, create, or actively seek out plan benefit designs that discriminate against people with disabilities. Benchmark plans, and the individual and small group plans designed pursuant to them, will be permitted to arbitrarily provide less comprehensive coverage of items and services within the EHB categories—regardless of how critical a particular item or service is to a protected class or whether Congress intended inclusion of the benefit within the mandatory EHB categories. While such designs may seem “neutral” on their face, because they technically apply to every enrollee, the devastating impact of, e.g., the exclusion of a wheelchair from a benefits package, is only felt by those inside the protected class of people with disabilities. Plans will be permitted to create and implement designs that limit the daily functioning of individuals with disabilities, while persons without disabilities will experience no such limitation. This disparate impact is unacceptable and unlawful under the ACA. DREDF is concerned that the new benchmark approach will permit and encourage such results.

Second, Section 1302(b)(4)(D) of the ACA requires the Secretary to “ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life.” As previously explained, the proposed rule will permit States to adopt benchmark standards that arbitrarily preserve or implement coverage exclusions and limitations on

¹⁴ 42 U.S.C. § 18116 (2012); 45 C.F.R. § 92.207 (2016).

¹⁵ 45 C.F.R. § 92.207 (2016); see also HHS Nondiscrimination in Health Programs and Activities; Final Rule, 81 Fed. Reg. 31,376, 31,440 (May 18, 2016) (interpreting Section 1557 to authorize a private right of action for claims of disparate impact discrimination on the basis of disability).

¹⁶ 42 U.S.C. § 18031(c)(1)(A) (2012); 45 C.F.R. § 156.225(b) (2016).

¹⁷ 45 C.F.R. §§ 156.110(d), 156.125 (2016).

health services and devices that individuals with functional impairments or chronic conditions depend on. Such “denials” will have a disparate impact on people who need therapies and devices to function within their communities. DREDF is concerned that the proposed rule will permit such results, counter to the Secretary’s duty to ensure the opposite.

Third, Section 1302(b)(4)(B) of the ACA provides that the Secretary cannot make “coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.” The agency’s decision to continue to abdicate responsibility for actively specifying EHB standards by leaving coverage decisions, reimbursement rates, incentive programs, and benefit design decisions to States and plans in the name of “flexibility” remains a decision made by the Secretary that, as explained above, results in discrimination against individuals with disabilities.

Fourth, Section 1302(b)(4)(C) of the ACA places the Secretary under a proactive duty to “take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.” While DREDF appreciates HHS’ proposal to codify this statutory requirement into the EHB regulations, the goal of this provision will not be effectuated by the new benchmark proposal. The health care needs of people with disabilities and other groups enduring health disparities will only be met when States and plans are encouraged to innovate benefit designs above a clear minimum floor of EHB coverage. The proposed rule, by its own terms, endorses *less* generous benefit designs. In the absence of clear mechanisms to encourage comprehensive and non-discriminatory EHB packages, the statutory duty to “take into account the health care needs of diverse segments of the population” is an empty promise.

B. Definition of “Typical Employer Plan” (Proposed § 156.111(b)(2)(i))

DREDF opposes HHS’ proposal to define a “typical employer plan” as a small or large group employer plan, or self-insured group health plan, with at least 5,000 enrollees in one or more States. As briefly mentioned above, 5,000 enrollees is an exceedingly low bar. For perspective, in 2017, there were an estimated 7,955,000 people enrolled in non-grandfathered individual and small group plans in California alone.¹⁸ A plan with 5,000 enrollees would constitute less than 0.06% of the enrollee population in the State. This remarkably low standard would allow States to design a set of benefits based on small outlier plans that may maintain arbitrary and atypical benefit designs. For people with disabilities, many of whom have complex medical needs and rely on EHBs to participate in their communities, allowing States to model their benchmark plan off these obscure policies could serve to entrench discriminatory benefit designs and promote less comprehensive coverage of EHBs.

Moreover, the benchmark supplementation requirements will do little to remedy the inadequacy of coverage that will result if an outlier plan is the model for a State’s

¹⁸ See CALI. HEALTH BENEFITS REVIEW PROGRAM (CHBRP), *Estimates of Sources of Health Insurance in California for 2017*, <http://chbrp.org/docs/Estimates%20of%20Sources%202017%20FINAL.pdf>.

benchmark. Pursuant to 45 C.F.R. § 156.110(b), States must supplement the entire EHB category if the benchmark plan does not include items and services within that category. However, to date, States have only taken advantage of the supplementation provisions when the benchmark did not cover *any* of the items and services in one of the ten EHB categories. Thus, an outlier plan that offers only minimal or facial coverage in a category (e.g., coverage with 100% co-insurance) is unlikely to trigger these statutory protections.

For these reasons, DREDF encourages the agency to constrain the definition of “typical employer plan” to a higher threshold enrollment standard that both takes into account State variations in the size of the enrollee population and meets a minimum floor of coverage in all ten EHB categories and the items and services covered within the categories. A fixed 5,000 enrollee standard is not large enough to represent “typicality” in a State like California or Texas, for example. Moreover, to comply with the ACA’s categorical EHB mandates and numerous prohibitions on disability discrimination,¹⁹ the definition must be limited to those plans that substantially cover the items and services within each of the ten EHB categories. To that end, DREDF would recommend defining “typical employer plan” as follows: “the largest health plan by enrollment that substantially covers all ten EHB categories and the items and services covered within each category in any of the State’s three largest products by enrollment.”

C. EHB Substitution (Proposed § 156.115(b)(1)(ii))

DREDF strongly opposes HHS’ proposal to allow substitution both within and between EHB categories. This approach, which was originally rejected by the Obama administration, would violate the text and legislative intent of the ACA by impermissibly delegating power to the plans to define the content of EHBs; allowing plans to deny meaningful coverage of the items and services covered within the statute’s ten EHB categorical mandates; and allowing plans to develop benefit designs that discriminate against people with disabilities.

Under this proposal, plans would be permitted to freely substitute EHB benefits among the ten mandated categories, provided there is actuarial equivalence. This approach would give a dangerous and inappropriate level of flexibility to the plans and could have a devastating impact on the people who rely on EHB benefits for daily functioning. Plans will be allowed to substitute the services and devices that individuals with disabilities depend on and replace those benefits with actuarially equivalent services that are less costly and catered to populations with fewer health care needs. For example, a plan could scale back coverage of chronic disease management or habilitative services, while increasing coverage of emergency services, so long as the substitution is actuarially equivalent. This policy could result in large gaps in coverage and high cost sharing burdens for individuals who need health care services to maintain their functioning. To be very clear, people with disabilities do not *desire* to receive their healthcare through emergency departments. They will do so when they lack health coverage for sufficient preventive and timely health maintenance services and devices.

¹⁹ See *supra* Part I.A for a more detailed discussion of these provisions.

Moreover, this proposal would increase confusion among consumers by making it far more difficult to compare plan options. The ACA was intended to *decrease* confusion in the health care marketplaces by encouraging the development of a uniform set of benefits that consumers could identify and understand. Allowing plans to substitute between the EHB categories will increase variation in benefit coverage, making the task of researching and selecting the right plan far more complex—especially when coupled with cuts to assistance from Navigators and shortened enrollment periods. For people with disabilities, many of whom need to thoroughly weigh their plan options to ensure adequate coverage of critical services and devices, this “flexibility” will prove to be an unnecessary and extremely time-consuming barrier to sufficient coverage.

Finally, while this proposal leaves open the option for States to adopt stricter standards that limit or prohibit substitution within or between EHB categories, only a few States took advantage of this option under the current substitution rule. Continued deference to the States is not a reliable method for ensuring the health care needs of people with disabilities are met.

D. Federal Default EHB Definition

DREDF appreciates that the agency is considering establishing a federal minimum definition of EHB for future plan years. We believe there is some promise to the general proposition *but only if* the agency develops a non-discriminatory and comprehensive EHB *minimum* benefit definition in each of the ten categories. If and when the agency publishes further details on this proposal, we look forward to providing comment on the specific content of that baseline definition.

While DREDF is optimistic that a federal minimum definition could help effectuate the health care rights of people with disabilities, we strongly oppose the idea to require States to defray costs if they choose to adopt their own benchmark plan that offers benefits in excess of the federal default. Section 1302(b)(5) of the ACA provides that nothing in the statute “shall be construed to prohibit a health plan from providing benefits *in excess of the [EHB definition]*” (emphasis added). While cost defrayal is not an explicit prohibition, it certainly is a strong deterrent and, for many States, may prove to be an insurmountable barrier to providing benefits beyond the federal minimum definition. It will discourage States and plans from innovating new and creative benefit designs to meet the complex health care needs of all enrollees, including people with disabilities and other diverse segments of the population. Moreover, cost defrayal will certainly inhibit states from the flexibility needed to effectively address ongoing local conditions due to public health crises such as the opioid epidemic or disasters where a State may wish to marshal private and public resources and regulatory authority to fashion a comprehensive multi-year recovery response.

In order to bring the EHB standards into compliance with the text and intent of the ACA and to ensure that the civil rights and health care needs of people with disabilities are taken into account, we recommend that the Secretary: (1) Develop a definition, with the full input of consumers, that clearly and unambiguously ensures that States and plans meet the requirements of a specified non-discriminatory EHB minimum benefit floor across all ten categories; and (2) Establish mechanisms for encouraging and

incentivizing State and plan innovation to maintain existing mandates that go beyond the minimum floor and develop additional products that will offer benefits “in excess” of the EHB minimum definition.

II. Cost Sharing Limits

DREDF opposes HHS’ proposal to increase the annual cost sharing limitations by 7 percent to \$7,900 individual and \$15,800 family. While we appreciate that the agency calculated this limit in accordance with the premium adjustment percentage methodology first established in the 2015 Payment Notice, we are concerned that—when coupled with the new EHB proposed rules—people with disabilities will experience higher out-of-pocket costs and hit the cost sharing limits sooner.

The proposed EHB rules, as acknowledged by the agency, are likely to decrease the comprehensiveness of benefit coverage in the individual and small group markets. With State benchmarks recognizing fewer services and devices as EHBs, critical items will be wholly excluded from plan benefit packages, while others will be covered with high copayment or coinsurance rates. This means that not only will consumers with high health care needs hit the cost sharing cap sooner, but they will also be absorbing out-of-pocket costs for essential items completely excluded from the plan benefit package. For people with disabilities, who have complex health care needs and disproportionately live in poverty, these higher costs will be particularly hard felt. For these reasons, we recommend that the agency consider revising the methodology to decrease the cost sharing burden on consumers.

III. Navigator Program Standards (Proposed § 155.210)

DREDF is concerned with HHS’ proposed changes to the Navigator program. Particularly in light of the recent and dramatic funding cuts to Navigator entities for the 2018 open enrollment period, continued enrollment assistance is critical to ensuring that people with disabilities have equal access to marketplace coverage and can select the best plan to meet their needs. The proposed rule will undermine the consumer protections currently in place and serve to further entrench the health care disparities of people with disabilities.

First, DREDF is opposed to the elimination of the requirement that each Exchange have at least two Navigator entities. Navigators are essential to ensuring that individuals with functional impairments and/or chronic conditions are enrolled in plans that provide the services and devices they need. Only requiring one Navigator entity in each Exchange is simply insufficient to meet the needs of the consumer population and its impact will be disproportionately felt among consumers who have complex or unique health care needs, those who are low-income, and those who live in rural areas and may be unable to access the one Navigator entity. We are concerned that this change will only exacerbate the disparities in health care coverage felt by people with disabilities and other diverse segments of the population.

Second, DREDF is opposed to the elimination of the requirement that one Navigator entity be a community and consumer-focused nonprofit group. Trusted and well-

established community-based nonprofits such as legal aid organizations, United Way affiliates, and food banks have been conducting outreach, educating consumers, and assisting with enrollment activities for the past four years. While we share the agency's goal of awarding Navigator grants to the strongest applicants, we firmly believe that community nonprofit organizations are in the best position to identify and best meet the needs of the consumer population. Regardless of "high scores," a chamber of commerce, trade association, or ranching and farming organization—for example—simply does not have the experience and in-depth understanding of the community to adequately serve them. Frontline, consumer-facing organizations, by the very nature of their work, are best qualified to reach and assist consumers, especially vulnerable and underserved populations.

Third, DREDF is opposed to the elimination of the requirement that each Navigator entity maintain a physical presence in the Exchange service area. We agree with the agency's acknowledgment that "entities with a physical presence and strong relationships in their [communities] tend to deliver the most effective outreach and enrollment results." Indeed, we believe that a physical presence in the Exchange is so important—especially for people with disabilities—that this requirement should not be optional. Individuals with disabilities, and particularly individuals who are Deaf or hard-of-hearing or have cognitive or developmental disabilities, can greatly benefit from in-person Navigator assistance. The factors that an individual must weigh when making an enrollment decision are numerous and complex. It is critical that that information is communicated in an accessible format and in a way that individuals can readily understand. In-person assistance can facilitate this goal and ensure that all consumers, regardless of disability and preferred communication method, have equal access to the health care marketplace. For these reasons, we urge the agency to reconsider changing the Navigator program standards.

IV. QHP Certification Standards

DREDF opposes the ongoing extension, for the 2019 benefit year and beyond, of the most recent Qualified Health Plan ("QHP") certification review standards relating to network adequacy (45 C.F.R. § 156.230). People with various disabilities cannot receive effective healthcare without network adequacy and the assurance that a QHP will have sufficient qualified primary care, specialist, and ancillary providers who are physically and programmatically accessible. HHS proposes deferring to state reviews for network adequacy where the State has "the authority to enforce standards that are at least equal to the 'reasonable access standard' defined in § 156.230 and means to assess issuer network adequacy." Unfortunately, a given state may have authority and means, but still lack the will or inclination to actively monitor and enforce network adequacy.

A 2014 Survey on State Insurance Standards prepared for the National Association of Insurance Commissioners ("NAIC") found that only a few States enforced network adequacy standards.²⁰ The primary means of monitoring is invariably complaint data,

²⁰ See *generally* HEALTH MANAGEMENT ASSOCIATES, ENSURING CONSUMERS' ACCESS TO CARE: NETWORK ADEQUACY STATE INSURANCE SURVEY FINDINGS AND RECOMMENDATIONS FOR REGULATORY REFORMS IN A CHANGING INSURANCE MARKET (2014),

which places the onus on consumers to both understand their network adequacy rights and have the resources to pursue those rights. In addition, only four States reported that they ever took more than one enforcement action **a year** against plans for network adequacy violations. While the NAIC updated and adopted a “Model Health Network Adequacy Law”²¹ for states to use in developing their own network adequacy laws, States are never *required* to actually adopt model laws in whole or in part. Each State regulator makes his or her own decision to regulate, monitor, and enforce health insurance plans for network adequacy. This is precisely why the federal rules on network adequacy are so important for QHP consumers across the nation, and why HHS’ abdication of its responsibility to, at the very least, proactively incentivize and monitor state review of network adequacy, is so important to people with disabilities.

For those States that lack the authority or means to enforce a State equivalent to a “reasonable access standard” defined in § 156.230, the proposal to continue to entrust network adequacy review to an issuer’s accreditation body is even worse. DREDF’s understanding of the accreditation process is that it is primarily accomplished before QHP’s actually engage with consumers, relies heavily on issuer attestation, and does not involve consumer or member feedback or even complaints. We are also unclear on how network adequacy elements contained in the three accreditation standards mentioned in the proposed rule—commercial, Medicaid, or Exchange—compare to the requirements of § 156.230, or who would actually judge whether those accreditation elements on network adequacy, or any state’s network adequacy requirements, are “equivalent” to those in § 156.230. Obviously consumers cannot be expected to individually peruse accreditation standards, State regulations, and federal network adequacy standards to determine for themselves if any given issues is in violation of the federal QHP requirements but if HHS, along with States, is only reacting to consumer complaints, the burden of monitoring and enforcement again is placed squarely on consumers. Finally, given the increasing propensity of issuers to stratify their networks according to product line and plan, it is unclear how accreditation of an issuer would or would not extend to multiple QHP products, or even across marketplace and non-marketplace products.

The disability community needs HHS to play a leading role in partnering with States to actively monitor and enforce network adequacy standards, and to encourage States to thoughtfully innovate in such areas as how to incorporate accessibility requirements within time and distance standards so that members with disabilities can actually see needed providers in their communities within a reasonable distance of their homes. In addition, network adequacy standards need to incorporate real-time information on providers who are truly taking new patients. For many members with disabilities, finding

http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf; see also MARK A. HALL & PAUL B. GINSBURG, BROOKINGS INST., A BETTER APPROACH TO REGULATING PROVIDER NETWORK ADEQUACY 7 (2017) (“Once regulators approve an insurer’s network adequacy plan . . . [r]ather than conducting routine audits or requiring periodic reports of actual compliance, state regulators usually rely on consumer complaints to highlight situations that might require investigation”), <https://www.brookings.edu/wp-content/uploads/2017/09/regulatory-options-for-provider-network-adequacy.pdf>.

²¹ See Health Benefit Plan Network Access and Adequacy Model Act, <http://www.naic.org/store/free/MDL-074.pdf>.

a provider is exacerbated by active discrimination. A study conducted in 2014 illustrates how network inadequacy can be exacerbated for patients with disabilities.²² 256 specialty providers were asked if they would accept a referral of a large patient who used a wheelchair and required transfer assistance. The study revealed that 22 percent (22%) of the specialty provider offices could not accommodate this patient, 4 percent (4%) were architecturally inaccessible and 18 percent (18%) could not assist the patient to transfer onto an exam table. Gynecology was the subspecialty with the highest rate of inaccessible practices (44%). Such lack of accessibility and impairment-related accommodation is commonplace not only among specialty providers, but also among primary care practices, diagnostic centers and facilities, clinics, and hospitals.²³ The patchwork of existing but unenforced network adequacy laws and regulations and network adequacy elements included in accreditation standards cannot provide the sustained effort and improvement that people with disabilities must have in order to gain equally effective healthcare in their communities. In addition, people with disabilities and chronic conditions who have ongoing healthcare requirements have a heightened need for the consumer safeguards that matter to all QHP members when it comes to network adequacy: adequate access to specialty and sub-specialty care, strong tested out-of-network exceptions request procedures and appeal rights, continuity-of-care protections, and protections from surprise out-of-network provider billing.

Finally, DREDF strongly requests a change in HHS's current reliance on State plan data review of QHP certification standards, particularly for non-discrimination implementation and enforcement, including for service area and prescription drug formulary outliers and non-discrimination in cost sharing. We believe that State identification alone of cost outliers will invariably miss historically entrenched discrimination with regard to issuer practices. For example, the \$2,000 DME cap in small group coverage that we discuss above in this comment existed in California among a great majority of issuers prior to passage and implementation of the ACA. The practice also continues after. The practice is therefore not an "outlier" because the many plans who continue to place caps, exclusions, and limitations on DME are not moving toward greater discrimination in the post-ACA era, so they will not necessarily be detected if the State reviews for such unusual discriminatory activity. Rather, the plans are discriminating because they are not **moving away** from the discriminatory practices that they already hold in common with regard to caps, cost sharing, and co-insurance of DME. Once again, HHS leadership and participation in the form of active review for non-discriminatory benefit design across states and between issuers will be much more effective than a simple reliance on State plan data and review practices and will give healthcare consumers with disabilities the national protection from discriminatory practices that they deserve.

DREDF supports HHS, and agencies such as CCIIO and HHS' Office for Civil Rights, continuing to play an ongoing strong role in ensuring non-discrimination among QHPs and we believe it is possible to do so while avoiding duplicative reviews. For example,

²² T. Lagu, N.S. Hannon, M.B. Rothberg, A.S. Wells, K.L. Green, M.O. Windom, K.R. Dempsey, P.S. Pekow, J.S. Avrunin, A. Chen, and P.K. Lindenauer, "Access to Subspecialty Care for Patients With Mobility Impairment: A Survey," *Annals of Internal Medicine* 158 (2013):441-446.

²³ T. Lagu, N.S. Hannon, M.B. Rothberg, A.S. Wells, K.L. Green, M.O. Windom, K.R. Dempsey, P.S. Pekow, J.S. Avrunin, A. Chen, and P.K. Lindenauer, "Access to Subspecialty Care for Patients With Mobility Impairment: A Survey," *Annals of Internal Medicine* 158 (2013):441-446.

HHS can establish relevant standards of review questions that all States should address and then States can do the actual reviews with the federal standards as a floor of inquiry and share information with HHS, who is the best position to do cross-State comparisons for discriminatory practices and policies and disseminate best practices and effective non-discrimination standards developed in individual States. A true federal-State partnership is needed to achieve the ultimate goal of empowering consumers and protecting them from entrenched as well as new discrimination practices.

V. Medical Loss Ratio

DREDF generally opposes the changes to the Medical Loss Ratio (MLR) calculations that are in the proposed rule. While we recognize the ongoing need in many states for market stabilization, we believe that HHS could productively prioritize and first pursue numerous other stabilization options and mechanisms, many of which have been addressed in detail by various consumer groups as well as NAIC consumer representatives individually, collectively and by their respective organizations. For the most part, issuers have adopted to the current MLR requirements, formula, and reporting requirements, and consumers have benefited from the quality improvement activities that have been incentivized by the MLR.

After NAIC submitted recommendations on the MLR to HHS, DREDF wrote to the organization to advocate for people with disabilities as a group that encounters significant systemic barriers to receiving effective clinical care and medical treatment, and that experience disparities akin to those that are rooted in ethnic, cultural and racial differences. Currently page 190-35 of the NAIC's model MLR regulation, Parts 3A & 3B on Improving Health Outcomes include "Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine." DREDF applauded NAIC's explicit recognition of Quality Improvement ("QI") activities that go towards reducing health disparities, and only raised the point that disability status should be included among the racial, cultural and ethnic disparities identified in the model MLR regulation. While persons with various disabilities and activity limitations encounter attitudinal barriers and failures to provide policy and procedural accommodations that could be regarded as "cultural," people with disabilities also encounter unique architectural, equipment, and communication barriers that do not easily fit under a ethnic, cultural or racial categorization. The inclusion of "disability status" among the disparities recognized as a QI expense would provide needed incentive to plans to undertake any of the following activities that would increase the effectiveness of standard healthcare examination and communication procedures for persons with disabilities:

- Assess and assure physical accessibility of provider facilities (including hospitals, laboratories and all kinds of treatment facilities);
- Assist providers to programmatically accommodate people with disabilities in needs that range from transfer assistance to extended appointment times to the provision of alternative formats like Braille for self-care directions;
- Incentivize the purchase, use and appropriate scheduling of accessible equipment such as height-adjustable weight scales and exam tables;

- Developing, establishing, and testing a mechanism that would allow a plan's network providers to pool funding and share scheduling for sign-language interpreters.

As with all MLR quality improvement activities, DREDF strongly agrees that reducing health disparities experienced by people with disabilities must be accompanied by accurate classification and adequate documentation of reported activities. For example, where employees are engaged in developing, testing and implementing activities to ensure physically and programmatically accessible healthcare for members with disabilities, their work must include expressly identifying the target disparity population, expected goals, and the outcomes achieved. To this end, DREDF does not support a simplification of the MLR reporting requirements that would allow issuers to simply report a single amount equal to 0.8 percent of earned premium in the relevant State and market, in lieu of tracking and reporting the issuer's actual expenditures for Quality Improvement Activities ("QIA"). In the face of numerous worthy goals, it is always easiest for a business or organization to repeat past activities. The suggestion in the proposed rule, to allow a single 0.8 percent figure which only needs to be further itemized if an issuer claims **more** than 0.8 percent in QIA both disincentivizes additional QIA spending, and allows issues to avoid undertaking innovative QIA. As disability advocates, DREDF continues to advocate both for the inclusion of QIA relating to decreasing the health and healthcare disparities experienced by people with disabilities, and for a clear and precise categorization of QIA that would allow advocates to track whether and how issuers are addressing disability-specific barriers.

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

Sincerely,



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