

March 2, 2020

*via Electronic Submission
(regulations.gov)*

Alex Azar, Secretary
Randy Pate, CMS Deputy Administrator & CCIO Director
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-9916-P
PO Box 8016
Baltimore, MD 21244-8016

RE: CMS-9916-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans (RIN 0938–AT98)

Dear Secretary Azar and Deputy Administrator Pate,

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 2021. 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. DREDF's work is based on the knowledge that people with disabilities of varying racial and ethnic backgrounds, ages, genders, and sexual orientations are fully capable of achieving self-sufficiency and contributing to their communities with access to needed services and supports and the reasonable accommodations and modifications enshrined in U.S. law.

DREDF has significant experience in health law and policy, given that disabled individuals disproportionately live in poverty and depend on health care services and supports. Our comments below do not address the full breadth of the proposed rule. Rather, we focus on provisions with particular relevance to people with disabilities.

I. Essential Health Benefits

DREDF opposes the proposal to require states to annually report benefit mandates enacted through state law. This proposal creates an unnecessary regulatory burden on states and, most importantly, it will deter states from improving or refining their EHB benchmark plans to more

adequately meet the local needs of their residents—a concern of particular importance to people with disabilities, many of whom rely on access to sufficient health care services and supports in order to function and contribute to their communities.

The ACA requires states to identify and defray the costs for mandates enacted after December 31, 2011. However, the Center for Consumer Information and Insurance Oversight’s (“CCIIO”) already publishes state mandates, their state code citations, and their year of enactment on its website,¹ making HHS’ proposal to require annual reporting a duplicative and unduly complicated burden. The proposal will effectively transfer authority to determine what constitutes a state mandate from state authorities to HHS. However, HHS provides no evidence showing that states are violating this federal requirement. The proposal will render state authority over mandate determinations meaningless, contrary to the intent of both the ACA and corresponding HHS regulations. It also runs contrary to principles of “state flexibility” that HHS has emphasized in previous Notices of Benefit and Payment Parameters.²

Moreover, the rule, if implemented, will discourage states from improving or even clarifying coverage in the individual and small group market using existing regulatory authority under the EHB benchmarking process. Several states are using current authority to update their EHB benchmark plans and expand services in critical areas. Under HHS’ proposal, states would need to submit an annual report that: identifies all state-required benefits regardless of whether those benefits are considered part of EHB; provides information explaining why the state believes the mandate is or is not part of EHB; and provides information about any mandate that has been amended or repealed. States will likely be reluctant to improve or expand benefits under the EHB benchmarking process, fearing that such improvements may run afoul of the complex mandate reporting requirements.

DREDF is particularly concerned with the impact this proposal will have on prospective state mandates relating to the statutory EHB categories of rehabilitative and habilitative services and devices (“RHSD”),³ prescription drugs, and mental health coverage—categories encompassing

¹ See *Information on Essential Health Benefits (EHB) Benchmark Plans*, THE CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, <https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb> (last visited Feb. 28, 2020).

² See, e.g., HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018).

³ 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).

critical items and services that enable people with chronic conditions and disabilities to maintain health and function, pursue education and employment, and participate in their communities.

As an example, consider the coverage (or lack thereof) of durable medical equipment (“DME”)⁴ in the California’s EHB benchmark plan. While the California benchmark plan includes some DME within its RHSD EHB category, it excludes other highly critical DME, such as wheelchairs, CPAP machines, and hospital beds,⁵ which other states do include in their benchmark. 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.

This proposal would make a state mandate correcting the dropped coverage of essential DME an even more burdensome challenge. These requirements represent a significant departure from the current standard, which requires states to inform HHS of state mandates and their corresponding date of enactment, without additional explanation for why the state believes the mandate triggers or does not trigger defrayal. Adopting these new requirements will effectively transform a workable and simple task into an arduous and complicated endeavor put in place as a solution to an inexistent problem. We strongly urge HHS to withdraw this proposal.

⁴ 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.

⁵ The State of California selected the Kaiser Small Group HMO 30 plan as its EHB benchmark plan. See CAL. HEALTH & SAFETY CODE § 1367.005. Implementing regulations from California Department of Managed Health Care (“DMHC”) codify the benefits included within this plan, and define the RHSD category to include DME “for use in the enrollee’s home” that is “substantially equal” to a list of nine enumerated DME items: canes, crutches, dry pressure pads, IV poles, enteral pumps, bone stimulators, cervical traction, phototherapy blankets, and some dialysis equipment. See CAL. CODE REGS. tit. 28, § 1300.67.005. Notably absent from this list is a number of quintessential DME items that happen to be more expensive; for example, wheelchairs, CPAP machines, oxygen tanks, and hospital beds are not included on this list. See *id.* § 1300.67.005(d)(5).

II. Automatic Reenrollment Process

DREDF opposes HHS' proposal to stop automatically renewing a marketplace enrollee's tax credit if the credit covers the full cost of the premium and the enrollee fails to annually update their financial information (even if there are no changes to report). The proposal will create new administrative red tape that will result in the wrongful disenrollment of consumers who face difficulties, or did not even know, they were supposed to update such information.

Under current rules, if a consumer does not update their income during marketplace open enrollment, the health plan renews for the next year with the same tax credits. HHS proposes to stop this automatic renewal if the enrollee's tax credit covers the full cost of the premium and the enrollee pays \$0. If consumers do not update their income and other financial information, they would have to pay a premium to reenroll. It proposes to withhold some or all of their tax credits until the consumer updates their financial information, even if there are no changes to report.

HHS says it would conduct outreach about this new process and reach out to consumers affected by such a change. Yet many people do not know they should update their information during open enrollment, especially if they have not experienced any significant financial change, and have been auto-reenrolling with \$0 premiums for a number of years. The result is they may not renew their plan if they get a bill from the insurance company for the full amount (even if they could get their premium tax credits restored if they update their information or obtain a refund from reconciling when they file their federal income taxes). Furthermore, outreach has not always proven effective in reaching certain consumers, due not only to confusion about how health insurance works, but also accessibility barriers, language fluency, and low health literacy.

DREDF is concerned that this proposal, whether the consumer would have to pay all or part of the premium to renew, would lead many individuals to lose their coverage. We strongly recommend HHS retain the current policies regarding automatic reenrollment.

III. Co-Pay Accumulators

DREDF opposes HHS' proposal to allow health insurance issuers to not count prescription drug coupons towards a consumer's deductible and out-of-pocket maximum.⁶ This proposed change, which HHS has already considered and rejected in the past, would make it even more difficult for consumers to afford medically necessary medications, and it will have a disproportionate impact on people with chronic conditions or disabilities who rely on prescription medications for their daily functioning.

⁶ 85 Fed. Reg. 7158 (proposed codification at 45 C.F.R. § 156.130(h)).

Many health care consumers struggle to afford prescription drugs due to high cost-sharing in the form of co-pays or co-insurance. High deductible plans also cause problems when consumers must pay out-of-pocket for services, including prescription drugs, until insurance will cover health care costs. For most individual and small group plans, including plans sold through the ACA Marketplaces in 2020, the out-of-pocket maximum is set at \$8,200 for an individual plan and \$16,400 for a family plan.⁷

For this reason, many consumers rely on pharmaceutical manufacturers' coupons to help defray cost sharing. However, in the proposed rule, health issuers would be permitted to not count coupons towards a consumer's deductible and out-of-pocket maximum. As a consequence, when coupons run out, the consumer may be required to pay the full amount for a drug until meeting the deductible; and continue to pay cost-sharing until reaching the out-of-pocket maximum. As a result, many individuals with disabilities or chronic conditions (such as HIV/AIDS) may no longer be able to access potentially life-saving medication because they cannot afford it, leading to disruptions in treatment and worse health outcomes.

HHS does not provide any reason for this proposed change, nor can we think of any. Health plan issuers already have many tools available to help steer consumers towards lower cost drugs. Many issuers require prior authorization for brand name drugs or require step therapy, whereby consumers must try and a cheaper generic version before being approved for a brand name drug. Yet for some prescription drugs (e.g., contraceptives) and for some medical conditions where treatment is highly individualized (e.g., Multiple Sclerosis), even step therapy is not appropriate.

Making consumers pay more for drugs, even where there is no generic equivalent, is punitive and would not achieve their broader policy goal of reducing prescription drug costs. DREDF strongly urge the administration to withdraw this proposal.

IV. Wellness Programs

DREDF opposes HHS' proposal to allow issuers in the individual market to include expenditures on health-contingent "wellness programs" as quality improvement activities in their medical loss ratio ("MLR") calculations. We are concerned that this proposal will induce more states and plans to implement wellness programs in their states, which will in turn have a discriminatory impact

⁷ See *Out-of-pocket maximum/limit*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/> (last visited Feb. 28, 2020).

on people with disabilities, who may not be able to participate in such programs or meet their outcome standards.

First, as a general matter, evidence has shown that workplace wellness programs do not improve health outcomes or reduce health care costs. In 2019, a randomized control study found no significant difference in clinical measures of health, including Body Mass Index (“BMI”), blood pressure, or cholesterol as a result of a workplace wellness program.⁸ The program also had no significant impact on employee absenteeism, job performance, or health care utilization.⁹ The evidence demonstrates that wellness programs are ineffective and thus it makes no sense for HHS to expand them into the individual market.

Second, DREDF is concerned that the expansion of wellness programs will result in further discrimination against people with disabilities. Disabled individuals experience significant access barriers in the health care setting, whether they be physical, programmatic, or attitudinal in nature.¹⁰ These barriers affect quality of care and result in disproportionately poor health outcomes for people with chronic conditions or disabilities.¹¹ For example, studies have found that people with disabilities are significantly more likely to experience obesity (58% v. 38% of the general population), diabetes (1.91% v. 0.68%), and cardiovascular disease (12.0% v. 3.4%).¹² By allowing issuers to vary the cost of coverage by up to 30 percent, HHS is creating an opportunity for plans to charge higher premiums to people with disabilities and chronic conditions who may be unable to participate in wellness programs or achieve the outcomes that they specify.¹³ Allowing health-contingent wellness programs in the individual market essentially would exempt issuers from the ACA’s ban on health status and disability discrimination.

For these reasons, DREDF opposes the proposal to consider wellness programs as quality improvement activities in their MLR calculations.

⁸ Zirui Song & Katherine Baicker, *Effect of a Workplace Wellness Program on Employee Health and Economic Outcomes: A Randomized Clinical Trial*, 321 J. AM. MED. ASSOC., no. 15, 1491, at 1491–1501 (Apr. 2019).

⁹ *Id.*

¹⁰ See, e.g., Silvia Yee, Mary Lou Breslin, et al., *Compounded Disparities: Health Equity at the Intersection of Disability, Race, and Ethnicity*, NAT’L ACADS. SCI., ENG’G, & MED., at 32 (2017), <http://nationalacademies.org/hmd/Activities/SelectPops/HealthDisparities/Commissioned-Papers/Compounded-Disparities>.

¹¹ *Id.*

¹² *Id.* at 138.

¹³ See, e.g., James H. Rimmer, et al., *Fitness facilities still lack accessibility for people with disabilities*, 10 DISABILITY & HEALTH J., no. 2, 214, at 214-21 (Apr. 2017).

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V. Special Enrollment Periods

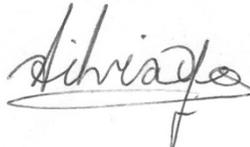
DREDF supports HHS' proposed changes to special enrollment periods. We appreciate HHS' proposal to allow consumers to move to a higher or lower qualified health plan metal tier if and when they become newly eligible for cost-sharing reductions. We also appreciate the acceleration of effective dates so that consumers will not have to wait as long for coverage to become effective. We believe these provisions will help ensure that enrollees have timely access to affordable and comprehensive health care coverage.

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,



Carly A. Myers
Staff Attorney



Silvia Yee
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