



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

December 21, 2015

VIA ELECTRONIC SUBMISSION

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

RE: Comments on CMS-9937-P; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017

Dear Administrator Slavitt:

As the co-chairs of the Consortium for Citizens with Disabilities Health Task Force, we are writing to provide comments on CMS's proposed Notice of Benefits and Payments Parameters for 2017. The Consortium for Citizens with Disabilities (CCD) is a coalition of more than 100 national consumer, advocacy, provider, and professional organizations advocating on behalf of people of all ages with physical and mental disabilities and their families for national public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

The following comments are to support the implementation of the Affordable Care Act in a way that achieves access to high quality, comprehensive, affordable health care for all Americans, including people with disabilities and chronic conditions. We would like to respectfully offer our concern about the extremely short comment period. The proposed rule was released just before the Thanksgiving break, formally published on December 2 and comments are due on December 21, 2015. The standards for issuers are key to the experience of consumers and the businesses in the exchanges. A longer comment period would have allowed time for a deeper, more beneficial analysis of what is working and what changes are being considered.

Essential Health Benefits

CCD appreciates CMS' clarification in last year's final rule of the rehabilitative and habilitative services and devices category of essential health benefits (EHBs) that sets a federal minimum definition of coverage. CCD was hoping that CMS would elaborate on this benefit category in this year's proposed rule, but it said little about this issue, despite the fact that most qualified health plans (QHPs) have instituted arbitrary caps in certain rehabilitative and habilitative health benefits, such as one-size-fits-all outpatient therapy caps. CCD requests CMS to include in the final rule an admonition to QHPs that

these types of arbitrary 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. CCD believes that if states choose to impose caps on rehabilitative or habilitative therapy services, they must not rely on disability-based distinctions and any such caps must be justified by legitimate actuarial data or actual or reasonably anticipated experience. In addition there must be an exceptions process to meet the needs of individuals who require more therapy than the cap allows for the person with average therapy needs. Imposing caps on coverage can easily serve as de-facto annual monetary caps on coverage, which violate ACA requirements.

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;
- 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.

#### State Mandates and Essential Health Benefits

CCD Health Task Force supports the proposed language for §155.170(a):

(2) A benefit required by State action taking place on or before December 31, 2011 is considered an EHB. A benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered in addition to the essential health benefits.

(3) The State will identify which State-required benefits are in addition to the EHB.<sup>i</sup>

CCD Health Task Force agrees with CMS that the revised §155.170(a)(2) is a clarification and thus does not anticipate an additional burden on States or issuers. We also agree that the revised §155.170(a)(3), which shifts responsibility from the Exchanges to the States, is a reasonable change. We understand that, as mentioned by CMS, exchanges have generally been relying upon State Departments of Insurance in determining what constitutes an essential health benefit. Thus, we do not anticipate any additional burden to States because of that modification.

CCD Health Task Force 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. We recommend that HHS assist states in incorporating all mandated coverage into EHBs and ensure that EHBs are covering the services that children and adults with disabilities or chronic conditions need.

#### 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.

#### Network Adequacy

We commend CMS for moving forward on establishing specific network adequacy standards for 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 would encourage CMS to require all states, not just those with FFEs, to adopt specific network adequacy standards.

CCD continues 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. Within the discussion of network adequacy, the importance of providers, and their offices, accommodating people with disabilities must be made central. Whether that is, for example, the physical space and equipment or language issues that could be a barrier, addressing these matters must be included in the consideration of what constitutes an adequate network.

#### NAIC Network Adequacy Model Act

CCD proposes that CMS add language suggested by the NAIC Network Adequacy Act to be inserted at the end of proposed rule 156.230(f)<sup>ii</sup> to state 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.)

#### Out of Network Cost-Sharing

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 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.

Specifically, 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 truly 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.

#### 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)

The CCD Health Task Force supports the intent to simplify the experience of shopping for a QHP through standardized benefit options. However, we do believe there is a need for caution. In the standardization process, if there are groups of benefits that are currently seen as 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 with disabilities or chronic conditions 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. Given the costs of multiple prescriptions required by people with disabilities and chronic conditions, the use of coinsurance makes a guessing game of what projected out of pocket costs for a plan may be.

#### 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 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.

Thank you for your consideration. If you have questions, please contact Mary Andrus at [mandrus@easterseals.com](mailto:mandrus@easterseals.com) or 202-247-3066.

Sincerely,

CCD Health Task Force Co-Chairs:

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Easter Seals

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<sup>i</sup> *Id.* at 75574.

<sup>ii</sup> *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017*; 80 Fed. Reg. 75586 (December 2, 2015). Available at: <http://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-29884.pdf>.