



Commemorating 40 Years
Of Disability Advocacy
1973-2013

March 15, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Regarding: Letter to Issuers on Federally-facilitated and State Partnership Exchanges

Dear Administrator Tavenner

CCD appreciates the opportunity to provide comments on the Letter to Issuers on Federally-facilitated and State Partnership Exchanges. CCD strongly urges CMS to provide clear direction and additional guidance on network adequacy, benefit design review, and meaningful access in order to ensure that the health plans offered in the health insurance marketplace will be effective for people with disabilities.

Our recommendations are summarized in the bullets below. Please see the remainder of the letter for our explanation.

CCD strongly recommends CMS edit the letter in the following manner:

- Include specific Network Adequacy criteria and requirements, as outlined in our letter, particularly around essential community providers and access to providers across the continuum of care (Chapter 1, Section 1);
- Expand the analysis of Qualified Health Plan (QHP) benefit design beyond cost-sharing provisions and specifically monitor compliance with nondiscrimination provisions within the ACA statute (Chapter 1, Section 4);
- Add “rehabilitation and habilitation services and devices” to the list of benefits to be monitored as part of the outlier analysis (Chapter 1, Section 4)
- Include requirements on disability and language accessibility in the provider network (Chapter 6, Section 3)
- Include draft language on meaningful access into the final letter (Chapter 6, Section 6)
- Explain the opportunity for states to establish stronger prescription drug access requirements other than the minimum number requirement in final EHB regulation; Strengthen the exceptions process by requiring protections, not suggesting them; and talk about the need to establish exceptions process for all EHB categories, not just for prescription drugs. (Appendix C)

Chapter 1: Certification Standards for Qualified Health Plans

Section 1 Network Adequacy and Inclusion of Essential Community Providers

i. Network Adequacy

We believe that CMS should require all QHPs to meet and adhere to specific network adequacy standards. People with disabilities must have access to and a choice of a wide variety of specialists, therapists and other providers that offer disability specific services in order to receive the medical care needed to maintain and improve function and overall health. Network adequacy must evaluate whether providers of essential health benefits are actually available to enrollees without unreasonable delay or travel. A standard that merely counts the numbers and types of providers should not be considered sufficient.

In addition, CMS must establish a robust monitoring and enforcement system that requires QHPs to publicly report compliance with network adequacy standards. CCD is concerned that the current proposal relies too much on a state's finding of network adequacy. CCD is also concerned that relying on plan accreditation will not be sufficient to ensure adequate networks. CCD urges CMS to provide additional guidance on network adequacy and essential community providers that addresses the issues discussed above and reflects the following principles:

- Access to providers of essential health benefits over the continuum of care (i.e. inpatient, outpatient and home and community based providers)
- Access to community-based providers, including non-profit providers, with a documented experience in serving persons with disabilities;
- Access to community-based providers defined in Section 340 (B) (a) (4) of the Public Health Service Act, as required by Section 1311 (c)(1) (C) of the Affordable Care Act (ACA);
- Geographic access, so persons with disabilities are not burdened with great traveling distances;
- Access to disability-specific specialists and services;
- Choice – each health exchange and qualified health plan (QHP) enrollee should have a choice of primary and specialized providers.
- Access—non-discrimination accommodation – all exchange and QHP providers must fully comply with the Americans with Disabilities Act and related civil rights requirements to ensure that persons with disabilities are appropriately provided services with respect and dignity and access to adequate accessible facilities and programs;
- Consistency with other HHS and ACA initiatives such as money follows the person, home and community-based expansions, and person-centered medical/home.

ii. Essential Community Providers

The Minimum Expectation of only 10% articulated in this letter is unreasonably low and does not guarantee a sufficient number and geographic distribution of providers to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area as required under the law. At a minimum, all issuers should be required to meet the Safe Harbor standard articulated in the letter. If an issuer fails to meet the Safe Harbor standard, the issuer should be required to show a good faith effort to contract with the required numbers and categories of essential community providers. The issuer should also provide a narrative description of how the insurer's provider networks, as currently designed and after taking into account new 2014 enrollment, provide an adequate level of service for low-income and medically underserved enrollees. It should be difficult for issuers that do not meet the Safe Harbor requirements to meet the regulatory standard.

Section 4 Benefit Design Review

i. Non-discrimination

CCD strongly supports CMS conducting an ongoing analysis of QHP practices in order to identify discriminatory benefit design. However, discriminatory benefit design encapsulates more than cost-sharing practices and CCD recommends that CMS monitor benefit design more broadly as part of its analysis. **To ensure that QHPs do not employ market practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs, we believe a deeper analysis, beyond a cost-sharing analysis, will be required and recommend CMS set up standards to do so.** CMS should look beyond cost-sharing and compare actual benefit designs for outliers on limits and restrictions, such as visit limits and prior authorization requirements, associated with specific benefits.

In addition, CMS' analysis of benefit design must focus on all ten categories of EHBs, not just the six categories CMS identified. In particular, CCD is very concerned that without proper monitoring of cost-sharing and utilization management techniques related to rehabilitative and habilitative services and devices, that discriminatory design will occur without identification or consequence. We strongly recommend CMS add "rehabilitative and habilitative services and devices" as well as "outpatient services" to the list of benefits and conditions monitored by CMS.

Ultimately, any standard utilized by CMS in this assessment must make clear that the determination of whether a coverage limitation or exclusion is discriminatory turns on the degree to which the benefit design is based on sound standards of clinical appropriateness rather than on arbitrary distinctions between health conditions or personal characteristics.

In particular, four provisions in the ACA specifically relate to nondiscrimination and CMS should specifically monitor compliance with them:

- § 1557 prohibits discrimination on the basis of race, color, national origin, language, sex, sexual orientation, gender identity, age and disability in health programs or activities that receive federal financial assistance, are administered by an Executive agency, or were established by Title I of the ACA.
- § 1302(b)(4)(B) requires that the Secretary "not 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."
- § 1302(b)(4)(C) requires the Secretary to "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups."
- § 1302(b)(4)(D) 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 the individuals' present or predicted disability, degree of medical dependency, or quality of life."

CMS should conduct a broad non-discrimination analysis of QHPs to identify where a state is not enforcing these standards. As part of this analysis, CMS should compare benefit designs for outliers on the limits and restrictions, such as visit limits and prior authorization requirements, associated with specific benefits.

Finally, CCD supports the review procedure proposed by CMS, whereby information contained in the "explanations" and "exclusions" sections of plans is reviewed to identify discriminatory practices or wording. It is of particular importance, as the draft Letter described, that exclusions or limitations that reduce the generosity

of benefits for subsets of enrollees without clinical rationale are flagged for review. We recommend that CMS provide more specific information regarding the standards for identifying types of exclusions or limitations that will result in review of benefits designs utilized by issuers. Examples of discriminatory benefit designs may include:

- Exclusions for otherwise-covered services for cases other than those in which the purpose of the treatment is to recover lost functioning or to restore previous levels of functioning. Such exclusions have a disparate impact on individuals with developmental disabilities who rely on services to attain certain functions or to avert their loss or deterioration. While the Affordable Care Act requires coverage of both rehabilitative and habilitative care, this requirement will mean little if issuers are permitted to continue to employ limited ideas of how broad the range of services covered under the category of habilitative care must be.
- Restrictions on “medically necessary” treatment within a benefit category to cases in which the services are required for the treatment of “illness, injury, diseased condition, or impairment.” This type of limitation is frequently used to deny coverage for health conditions classified as being present at birth rather than the result of a disease process.
- Exclusions for mental health, substance use disorder, and behavioral health treatments that fail to meet the parity standards required by the Mental Health Parity and Addition Equity Act of 2008 (MHPAEA). Despite these existing parity requirements, state implementation and enforcement of MHPAEA has varied widely. Additionally, patients seeking mental health services are frequently subjected to excessive and inappropriate non-quantitative limitations.

Chapter 6: Consumer Support

Section 3: Provider Directory

CCD supports the requirements for a provider directory and the encouragement of including the languages spoken. CCD strongly recommends that CMS require issuers to identify providers who have accessible equipment for individuals with disabilities. We also suggest that issuers ensure that any provider that includes a language spoken by the provider or his/her staff have sufficient language competency in that language.

Specifically, CCD recommends that CMS amend the requirements regarding provider directories to read as follows:

. . .CMS encourages issuers to include information such as whether the provider is accepting new patients, languages spoken, provider credentials, and whether the provider is an Indian provider, *and detailed accessibility information (e.g., “exam table lowers to __ inches,” “platform scale available for wheelchair users,” “bathroom meets ADA Accessibility Guidelines,” “transfer assistance provided upon request,” “alternative formats such as Braille, large font or electronic disc or mail available upon request,” “Sign language interpretation available upon request,” “examination room with __ turning radius available upon request,” and/or “extended appointment time available upon request when facilitated communication is required in the appointment.”)* At the very least, provider directories will provide contact information for customer representatives who will assist health plan members and the public to determine whether and which network providers have the accessibility features that a member or perspective member requires to receive effective health care services.

Section 6: Meaningful Access

We strongly support including information on meaningful access for individuals with disabilities and individuals who are limited-English proficient (LEP). However, we believe the final letter fails to provide sufficient information to issuers to understand the depth and breadth of assistance they must provide. We strongly support specific, detailed requirements as individuals whose health and lives are at stake – which is the case when they are accessing healthcare services – must be able to actively participate and communicate with their insurers and healthcare providers. Without such accessibility, issuers will likely offer substandard assistance to certain groups of individuals who are potentially at the highest risk of needing assistance.

In order to ensure meaningful access by limited-English proficient speakers and by people with disabilities, the Exchange Final Rule requires that QHP issuers provide all applications, forms, and notices to enrollees in plain language and in a manner that is accessible and timely to individuals living with disabilities and individuals with limited English proficiency. (*See* 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250). Additionally, 45 C.F.R. § 156.200(e) prohibits QHP issuers, with respect to QHPs, from discriminating on the basis of race, color, national origin, or disability.

Certain Federal civil rights laws also apply to QHPs. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin (including primary language) by entities that receive Federal financial assistance. Section 504 of the Rehabilitation Act of 1973 includes an obligation to provide individuals with disabilities an equal and effective opportunity to benefit from or participate in a program receiving Federal financial assistance or under any program or activity conducted by a Federal Executive Agency.

CCD believes there is no question that these civil rights and non-discrimination requirements apply to issuers' activities when functioning as QHPs in Exchanges. The Exchanges themselves must comply with Title VI of the Civil Rights Act of 1964, the Rehabilitation Act, the Americans with Disabilities Act and section 1557 of the Affordable Care Act as direct recipients of Federal funding. Similarly, issuers are recipients of federal financial assistance by accepting federal funding to help pay the premiums and cost-sharing for lower-income individuals participating in the Exchanges. Further, section 1557 applies to the issuers since Exchanges are created under Title I of the Affordable Care Act. It would be an absurd result if the Exchanges themselves are subject to § 1557 but not their subcontractors.

To assist QHP issuers in complying with the standards established in 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250, we outline a safe harbor approach for issuers. QHP issuers can satisfy meaningful access standards by implementing the measures described in the following paragraphs.

Safe Harbor Measures: The measures outlined in this paragraph are evidence of compliance with the regulatory requirements established by 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250.

Language Access

- Applications and notices, as described in the list below, produced or used by QHP issuers should be available in the languages spoken by the state's top ten largest LEP groups or spoken by 10,000 persons or greater, whichever yields the greater number of languages. Said documents should also include taglines in the top 30 non-English languages in the state indicating the availability of free language assistance services through a QHP issuer's call center.
- QHP issuers should offer oral interpretation, such as through telephonic interpreter services via a call center, in 150 languages, for notices and applications.

- QHP issuer Websites that contain information about QHPs, including applications and notices, should have taglines in the top 15 non-English languages in the state indicating the availability of free language assistance services through a QHP issuer’s call center. Websites with content in English should be translated into Spanish, and applications and notices appearing on issuer Websites should meet the standards above.

Access for Individuals with Disabilities

- Applications and notices, as described in the list below, must be provided, as requested, in alternate formats, including Braille, large print, or another effective method of making visually delivered materials available to individuals with disabilities, including individuals who are blind and who have low vision.
- Applications and notices, as described in the list below, should be in plain language and presented at or below the 6th grade proficiency and comprehension level.
- Call centers operated by QHP issuers must include telecommunications relay services to effectively serve persons who are deaf and hard of hearing.
- QHPs are required to inform consumers of the availability of auxiliary aids and services such as qualified interpreters, note-takers, and materials in alternate formats.
- QHPs must provide auxiliary aids and services at no cost to the consumer.
- Websites and electronic documents must be compatible with screen reader software.
- Websites and electronic documents must meet Section 508 standards or standards that provide greater accessibility to persons with disabilities.

QHPs are reminded that these meaningful access requirements are independent of other obligations QHPs may have, but also interact with those other obligations. For example, there are specific requirements relating to Essential Community Providers who are Integrated Issuers, requiring them to describe the extent to which provider sites are accessible to specific underserved populations. One of those populations is “low-income and underserved individuals seeking women’s health and reproductive health services.” The general inaccessibility of mammography machines and reproductive services to low-income women with mobility disabilities is well-documented, and certainly constitutes a lack of “meaningful access” within this specific underserved population group. Moreover, people with disabilities do not have meaningful access overall to health care services if QHP provider networks are physically and programmatically inaccessible, or if providers discriminate by failing to offer reasonable accommodations and policy modifications, such as accessible equipment, modified appointment times, assistance with filling forms, and sign language interpreters, to people with various disabilities. In terms of meaningful communication access, and in accordance with 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250, meaningful access includes but is not limited to the use of accessible websites and the provision of auxiliary aids and services in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

A QHP issuer that does not implement the safe harbor measures may demonstrate compliance with meaningful access standards by developing and submitting a plan or strategy to provide meaningful access for persons with limited English proficiency and persons with disabilities.

QHP issuers that implement the safe harbor measures are also encouraged to develop and submit such a plan. The plan or strategy should include at least the following:

- How to identify persons with limited-English proficiency or with disabilities;
- The types and extent of assistance services available;

- How to provide notice to persons with limited-English proficiency or with disabilities of the availability of appropriate assistance services;
- How to communicate with persons with limited-English proficiency or with disabilities on the phone, in writing, and in person; and
- A schedule and process for monitoring and updating the plan.

CMS expects that QHP issuers will ensure meaningful access to at least the following essential documents:

- Applications (including the single streamlined application),
- Consent, grievance, and complaint forms, and any documents requiring a signature,
- Correspondence containing information about eligibility and participation criteria,
- Notices pertaining to the denial, reduction, modification, or termination of services, benefits, non-payment, and/or coverage,
- A plan’s explanation of benefits or similar claim processing information,
- QHP ratings information,
- Billing notices and financial statements,
- Rebate notices, and
- Any other document that contains information that is critical for obtaining health insurance coverage or access to care through the QHP.

Furthermore, QHP issuers must inform individuals of the availability of the services described above, instruct LEP consumers and consumers with disabilities how to access these services and supports, and indicate to applicants and enrollees that said services will be provided at no cost to them.

Appendix C Additional Guidance on EHB Prescription Drug Coverage, Actuarial Value, and Cost Sharing

ii Prescription Drug Exceptions Process

People with disabilities or chronic conditions need access to a robust range of medications, and many people with disabilities often have multiple health conditions that require multiple medications. We recommend HHS include the Medicare Part D requirement to cover “all or substantially all” of the drugs in six protected classes of drugs in the final rules. Though positive changes were made related to prescription drugs, we strongly believe the proposed EHB rule continues to fall short on ensuring patients have access to a full range of medicines, including new therapies.

The proposed standard emphasizes a minimum number of drugs in a class without regard to the type of covered drugs, thereby potentially excluding certain drugs that may provide important therapeutic benefits. The quality of medications must also be emphasized in plan formularies. CCD has urged CMS to ensure that QHP offer robust prescription drug plans to meet the need of people with disabilities. When designing formularies to serve people with disabilities, special attention must be paid to the side effect profiles, the capacity of drugs to worsen conditions common to people with disabilities, contraindications, interactions with other medications and appropriate dosage forms –this argues for a wider range of drugs being available to this population. Individuals with cognitive impairments may be less able to articulate problems with side effects making it more important for the doctor to be able to prescribe the best medication for the individual. The availability of alternative formulations of a drug, such as extended release versions, may also be important to effectively managing these serious and complex medical conditions.

Our concerns about inadequate prescription drug plans in QHPs make it even more critical to ensure that plans have an effective exceptions process. CCD agrees that a health plan must have procedures in place that allow an enrollee to request and access clinically appropriate drugs not covered by the health plan. In general, we support the proposal outlined in the letter but urge CMS to establish these steps and timelines as a required minimum standard that plans must meet, rather than “suggesting” the practices.

For example, consistent with the Medicare Part D program, CMS should *require* that a drug is clinically appropriate, and should be covered, if an oral or written supporting statement is submitted from a prescriber and establishes that the requested prescription drug is clinically appropriate to treat the enrollee’s disease or medical condition

CCD continues to believe that such an exceptions process should be established for all categories of EHB, not just prescription drugs.

CCD appreciates the opportunity to provide comments on the proposed letter. If you have questions about our comments please contact Julie Ward, The Arc, (ward@thearc.org).

Sincerely,

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