



**CONSORTIUM FOR CITIZENS  
WITH DISABILITIES**

February 25, 2014

Kathleen Sebelius  
Secretary of Health and Human Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
Washington, D.C. 20201

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

Dear Secretary Sebelius:

The Consortium for Citizens with Disabilities (CCD) Health Task Force appreciates the opportunity to provide comments on the Letter to Issuers on Federally-Facilitated and State Partnership Exchanges. CCD is pleased that the Letter provides additional consumer protections beyond the 2014 Letter but urges CMS to provide additional guidance on network adequacy, benefit design review to ensure compliance with federal regulations (including nondiscrimination), and meaningful access to ensure that the health plans offered in the health insurance marketplace will be effective for people with injuries, illnesses, disabilities, and chronic conditions.

**Chapter 1: Certification Process and Standards for Qualified Health Plans**

Section 3, Part ii. Review of QHP Rates

In this section, CMS proposes to "...conduct an outlier analysis on QHP rates to identify rates that are relatively high or low compared to other QHP rates in the same rating area." We applaud the overall concept of an outlier analysis for each rating area. However, the Draft Letter to Issuers does not provide any detail about how outliers are defined. For example, is this based on an aggregated measure of rates for an issuer across all plans, or for individual QHPs? Will CMS look at outliers in each metal tier? Will CMS only look at the very highest and lowest rates or will CMS use a threshold that reviews any QHP with a rate a certain percentage above or below the median or mean rate? We encourage you to provide more detail, and to allow disability and consumer advocates to work with you to determine how outliers are defined.

## Chapter 2: Qualified Health Plan and Stand-alone Dental Plan Certification Standards

### Section 3. Network Adequacy

We strongly support a more intensive review of proposed QHPs' provider networks, as proposed in the Letter. We support the use of accreditation status, state reviews, and issuer access plans to assess QHP network adequacy, but we strongly favor CMS's proposal to also require issuers to directly submit provider lists to CMS for evaluation of whether the provider networks meet a "reasonable access" standard.

We believe that CMS is moving in the right direction by reviewing proposed provider lists to assess both reasonable access and whether networks provide access to care without unreasonable delay. However, we believe that stronger standards are needed. People with disabilities must have access to, and the choice of, a wide variety of specialists, therapists and other providers that offer disability-specific services in order to receive the medical and rehabilitative care they need to maintain and improve function and overall health. CCD urges CMS to provide additional guidance on network adequacy and essential community providers that addresses the issues discussed above. Such guidance should reflect the following principles:

- Appropriate access to providers of services and devices over the continuum of care (i.e. inpatient, outpatient and home and community-based providers)
- Appropriate access to community-based providers (which is not required) should be broadly interpreted to include non-profit providers with a documented experience in serving persons with disabilities;
- Appropriate 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);
- Appropriate geographic access, so that persons with disabilities are not burdened with traveling unreasonable distances given their health condition;
- Appropriate access to disability-specific specialists and services;
- Appropriate choice – each health exchange and qualified health plan (QHP) enrollee should have a choice of primary and specialized providers.
- Appropriate access – nondiscrimination and 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 treated with respect and dignity and given access to adequate accessible facilities and programs;
- Access to sufficient pediatric services including specialists and children's hospitals which frequently provide essential services to children with disabilities and specialized health care needs.
- Consistency with other HHS and ACA initiatives such as "Money Follows the Individual," home and community-based expansions, and person-centered medical/health home.

When CMS determines that an issuer's network is inadequate under the reasonable access review standard, it should instruct the issuer to offer contracts to additional providers (including providers located outside of the QHP's service area, but still within a reasonable distance for enrollees), or modify the terms of the contracts the issuer has already offered to be more acceptable to necessary

providers. CMS should review the contracts offered by issuers that are found to have inadequate networks to assess whether they are reasonable. If, even with reasonable contract terms, an issuer cannot secure a sufficient number of providers in given categories, the issuer should be required to allow enrollees to receive services out-of-network at in-network cost-sharing rates without prior authorization, and the issuer should bear the cost of any balance billing by the provider.

We also strongly support CMS implementing a searchable provider directory for FFM QHPs. Consumers should be able to search by a provider's name and see all QHPs in the FFM for which that provider is in network. This searchable directory should be accessible to consumers when they are "window shopping," before they create a marketplace account.

CCD is pleased that the minimum expectation of essential community provider (ECP) coverage has been raised this year. We remain concerned that 30% is insufficient to meet the needs of low-income, medically underserved individuals in the QHP's service area. At a minimum, CCD urges CMS to increase the required coverage to 40% and raise that percentage each year until the intent of the law is met.

In addition, we are concerned that a mere "good faith offer" of a contract to at least one of each type of ECP will not be sufficient to meet the goals of the statute. We recommend that each QHP be required to include at least one of each type of ECP in its network, and to clearly identify which ECPs are in-network in its information for enrollees and potential enrollees.

Finally, CMS should consider establishing separate categories of ECPs to meet the special needs of people with disabilities, including children with disabilities. We believe that children's hospitals merit designation as a separate ECP category, since many children with complex medical needs or disabilities can get critical services only at a children's hospital. In addition, some of the other types of ECPs currently in the "other ECP" category might merit their own separate categories to ensure that the needs of all enrollees are met. For example, under the current and proposed requirements, Hemophilia Treatment Centers (HTCs) could be excluded from a QHP's network, even though the majority of those with this diagnosis receive some treatment from HTCs.

## **Chapter 3 Qualified Health Plan and Stand-Alone Dental Plan Design**

### **Section 1: Discriminatory Benefit Design: 2015 Approach**

#### **i. EHB Discriminatory Benefit Design**

The letter to issuers indicates that CMS will largely rely on state reviews of essential health benefits (EHB) for discriminatory benefit design when certifying QHPs for the FFM. It is critical that individual and small group plans offered in FFMs fully comply with the EHB requirements prohibiting benefit designs that discriminate against individuals on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation. As we have expressed in previous comments on the NPRM Standards Related to Essential Health Benefits, Actuarial Value and Accreditation, we have significant concerns that there currently is not a clear

standard for assessing whether or not a state is adequately reviewing plans' compliance with nondiscrimination requirements for EHB. We believe it is critical that CMS issue guidance that establishes clear standards for the breadth of plan elements that states must review as part of assessing compliance with these requirements. This guidance should specify that states need to have robust methods for reviewing the following plan elements for discriminatory practices: covered benefits and drug formularies, medical necessity definitions, exclusions, provider networks, benefit substitution, waiting periods, service areas, rating, visit limits, and utilization management.

This guidance should also outline best practices from states and recommend methods for reviewing these plan elements for discriminatory design. It should also include concrete examples of discriminatory benefit design for each of the above plan elements and across the many protected classes of consumers. This guidance should be publicly available.

It is also vital that there is a clear and transparent process in place for consumers to directly file complaints to CMS about discriminatory practices and benefit design they observe or experience in plans.

#### ii. QHP Discriminatory Benefit Design.

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 simply 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 as well as medical necessity definitions; exclusions, provider networks, benefit substitution; and waiting periods. We support the CMS proposal to add a review of medical management techniques such as prior authorization and step-therapy requirements for prescription drugs to its review process in 2015.

It is critical to review the four provisions in the ACA that specifically relate to nondiscrimination, and to develop methods for CMS to 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.”

These four provisions provide CMS ample authority to implement stronger provisions to prevent discrimination.

Additionally, we support 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 describes, that exclusions or limitations that reduce the generosity of benefits for subsets of enrollees without a clinical rationale are flagged for review. We recommend that CMS provide more specific information regarding the standards for identifying the types of exclusions or limitations that will result in a review of the 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.

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.

We also support more direction on coverage for habilitative services, especially a reasonable exceptions process, and ask CMS to include language like that offered in the Office of Personnel Management Multi-State Plan Program Issuer Letter released February 4, 2014. That Letter, under Section II(D)(2), notes that: “[w]e recognize that coverage of habilitative services as an essential

health benefit is evolving. Lacking a standard definition, many issuers have begun by offering habilitation in parity with rehabilitative services. However, the duration and scope of services an individual may need to acquire skills for the first time may differ from what a person may need to regain function after illness or injury. To accommodate such unique circumstances, we encourage MSP issuers to provide a reasonable “exceptions process” to consider requests for additional habilitative services when such services are medically necessary to achieve a therapeutic milestone or avoid significant deterioration in health status.”

## **Chapter 6: Consumer Support and Related Issues**

### Section 1: Provider Directory

CCD supports the requirements that QHPs provide a direct phone line listed online for an up-to-date provider directory that is specific for the QHP. CCD strongly recommends that CMS require issuers to identify providers who have accessible equipment for individuals with disabilities.

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 requires to receive effective health care services. (additions in italics)

### Section 4: 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, since an individual’s health and life is at stake when they are accessing healthcare services, he or she 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. We are pleased that CMS is planning to further address specific standards in future rulemaking and offer our assistance in developing the standards.

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](mailto:ward@thearc.org)).

Sincerely,

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