



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

November 27, 2017

VIA ELECTRONIC SUBMISSION

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9930-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Consortium for Citizens with Disabilities Health Task Force: Comments on HHS Notice of Benefit and Payment Parameters for 2019 (RIN 0938-AT12)

Dear Administrator Verma:

The undersigned co-chairs of the Consortium for Citizens with Disabilities (CCD) Health Task Force appreciate the opportunity to comment on the proposed rule *HHS Notice of Benefit and Payment Parameters for 2019*¹ (the Proposed Rule). CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society.

The Proposed Rule sets forth benefit and payment parameters, provisions related to essential health benefits (EHBs), qualified health plans (QHPs), risk adjustment, and the operation of Federally-facilitated exchanges (FfEs) and State-based exchanges (SBEs), as well as many other policies implementing the Affordable Care Act (ACA). This comment letter will focus on key proposed provisions that specifically impact persons with disabilities and chronic conditions, including:

¹ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 82 Fed. Reg. 51,052 (Nov. 2, 2017). Available at: <https://www.gpo.gov/fdsys/pkg/FR-2017-11-02/pdf/2017-23599.pdf>.

- Rules related to the essential health benefits, including specific examples for the category of “rehabilitation and habilitation services and devices”;
- Provider network adequacy requirements;
- Navigator program standards; and,
- Non-discrimination protections and certification of Qualified Health Plans.

I. Essential Health Benefits

Essential Health Benefits (EHB) are absolutely crucial for ensuring that people with disabilities have access to needed healthcare services. For example, one of the key essential benefits is rehabilitation and habilitation services and devices. Rehabilitation is provided to help a person regain, maintain, or prevent deterioration of a skill, condition, or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition. Rehabilitation services are essential to enable people with injuries, illnesses, and disabilities to:

- Improve, maintain, or slow deterioration of health status;
- Improve, maintain, or slow deterioration of functional abilities;
- Live as independently as possible;
- Return to work, family, and community activities as much as possible;
- Avoid unnecessary and expensive re-hospitalization and nursing home placement; and
- Prevent secondary medical conditions.

Rehabilitation services are closely related to habilitation services, which focus on skills, conditions, and functions that were never acquired. Rehabilitative and habilitative services and devices include but are not limited to rehabilitation medicine, inpatient rehabilitation hospital care, physical and occupational therapy, speech language pathology services, behavioral health services, recreational therapy, developmental pediatrics, psychiatric rehabilitation, and psycho-social services provided in a variety of inpatient and/or outpatient settings.

Whereas *rehabilitative services* are provided to help a person regain, maintain, or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition, *habilitative services* are provided in order for a person to attain, maintain, or prevent deterioration of a skill or function *never learned or acquired* due to a disabling condition. The only meaningful difference between habilitation and rehabilitation is the reason for the need for the service: whether a person needs to attain a function from the outset or regain a function lost to illness or injury.

There is a compelling case for coverage of both rehabilitative and habilitative services and devices for persons in need of functional improvement due to disabling conditions. These services and devices are designed to maximize the functional capacity of the individual, which has profound implications on the ability to perform activities of daily living in the most independent manner possible. Both rehabilitative and habilitative services and devices are highly cost-effective and decrease downstream costs to the health care system for unnecessary disability and dependency.

There are other essential health benefits that are equally crucial to people with disabilities and chronic conditions, including mental health and substance use disorder services, prescription drugs, preventive and wellness services, and chronic disease management. Access to all of these benefits is addressed below.

II. Regulatory Background on Essential Health Benefits

The Affordable Care Act includes statutory language that requires coverage of essential health benefits. Inclusion of this language in the statute was a major milestone for the disability community in that Congress recognized the importance of these benefits to improve the health and functioning of the American people.

Additional regulatory action, especially related to the statutory EHB category known as “rehabilitation and habilitation services and devices” helped to flesh out these important benefits. In the February 2015 Notice of Benefit and Payment Parameters Final Rule,² the Centers for Medicare and Medicaid Services (CMS) defined “rehabilitation services and devices” as follows:

“Rehabilitation services and devices—Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.”

In the February 2015 Notice of Benefit and Payment Parameters Final Rule,³ the Centers for Medicare and Medicaid Services (CMS) defined “habilitation services and devices” as follows:

“Habilitation services and devices—Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.”

For the first time, these regulations established a uniform definition of rehabilitation and habilitation services and devices that states could understand and consistently implement. This definition became a standard for private insurance coverage, a floor of coverage for individual insurance plans sold on the exchanges. Importantly, the definitions include both rehabilitative and habilitative *services* and rehabilitative and habilitation *devices*. The adoption of federal definitions of rehabilitation and habilitation services and devices minimized the variability in benefits across States and the uncertainty in coverage for children and adults in need of these vital services.

While there was not a federal regulatory definition for many other benefits, states have taken steps to supplement their plans to comply with other laws, such as the Mental Health Parity and

² Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,811 (Feb. 27, 2015).

³ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,871 (Feb. 27, 2015).

Addiction Equity Act (MHPAEA) and other non-discrimination requirements. States have also taken into consideration their own specific mandated benefit coverage.

III. Flexibility to States in Establishing Essential Health Benefits

The proposed rule seeks to grant states additional flexibility to tailor their benchmark benefit coverage to attempt to lower costs and, thereby, expand insurance options for consumers. While expanded coverage options and lower health care costs are two important goals, we urge the final rule to balance these goals against the statutory requirements for EHB coverage, as well as the nondiscrimination provisions of the ACA. Adhering to these statutory requirements of the ACA will decrease the likelihood that additional flexibility will lead to the emergence of bare-bones benefit packages, particularly in the areas of rehabilitation and habilitation services and devices. CCD has specific concerns, outlined below, about each of CMS's proposals to grant states additional flexibility and discretion in designing their EHB benchmark plans, including CMS's revised definition of a "typical employer plan."

In the Proposed Rule, CMS states that, starting in plan year 2019, States would be permitted to change their EHB benchmark plan annually by:

- Selecting the EHB-benchmark plan that another State used for the 2017 plan year under § 156.100 and § 156.110;
- Replacing one or more EHB categories of benefits under § 156.110(a) in its EHB benchmark plan used for the 2017 plan year with the same categories of benefits from another State's EHB-benchmark plan used for the 2017 plan year under § 156.100 and § 156.110; or,
- Otherwise selecting a set of benefits that would become the State's EHB benchmark plan, provided that the EHB benchmark plan does not exceed the generosity of the most generous of among a set of comparison plans.

CMS further states that, under this proposal, a state's EHB benchmark plan must be equal in scope to the benefits provided under a "typical employer plan." This requirement reflects the statutory requirement in the ACA that the scope of EHBs must be equal to the scope of benefits provided under a typical employer plan. In the proposed rule, CMS proposes to revise the definition of a "typical employer plan" as "an employer plan within a product (as these terms are defined in § 144.103 of this subchapter) with substantial enrollment in the product of at least 5,000 enrollees sold in the small group or large group market, in one or more States, or a self-insured group health plan with substantial enrollment of at least 5,000 enrollees in one or more States."

Specific Concerns Regarding Each EHB Benchmark Plan Design Option in the Proposed Rule

CCD Health Task Force appreciates the efforts to limit cost in order to promote the availability of coverage. But CCD is concerned that the additional options available to states to redefine their benchmark benefits coverage may create a "race to the bottom" in the scope of coverage

available to consumers in the various states. Rehabilitation and habilitation services and devices, mental health and substance use disorder services, prescription drugs, and the other EHBs are simply too important to allow States to substantially limit these benefits in redefining new EHB benchmark plans. These benefits must be available to individuals when they truly need them. Access to essential health benefits can save significant health care dollars in the long term and reduce the need for more intensive health care services later in life.

Specifically with respect to the first and second proposed options that would allow States to substitute either their entire EHB benchmark plan with the plan of another State or would allow States to replace one or more EHB categories of benefits with that of another State, CCD is deeply concerned that States will exercise this option to select a more limited benefit package than they currently offer. CCD has significant concerns with the EHB benchmark plan selection and benefit substitution proposals as they will erode consumer protections and comprehensive coverage. Consumers with specific health needs would be impacted based on the approach selected by their state.

With respect to the third option, which would essentially allow States to rewrite their own benchmark plans while imposing a limit on the benchmark plan's generosity, CCD is concerned that this will contribute to a significant decrease in coverage of EHBs, particularly rehabilitative and habilitative services and devices, mental health and substance use services, prescription drugs, and other crucial disability-related health care services. By granting States expansive power to alter their EHB benchmark plans so dramatically every year, the Proposed Rule threatens any hope of predictability of coverage for consumers from year-to-year and State-to-State. This will likely reduce quality of care and increase downstream costs due to a lack of predictability in coverage of these essential services and devices.

Furthermore, CMS's proposed definition of a "typical employer plan" would considerably weaken EHBs and allow states to search out the most sparing plans in the nation. As a result of the lack of constraints placed on what constitutes a "typical employer plan," these plans would hardly be "typical" and CMS's proposed definition would allow states to disregard the differences in health care needs between the populations of different states in establishing their benchmark plans. CCD supports CMS's suggestion that the definition of typical employer plans should be limited to plans that already cover all 10 EHB categories. Furthermore, a typical employer plan should have to be from a recent year, as well as be required to meet minimum value standards or not be an indemnity plan or a health reimbursement arrangement.

Congressional Intent and Statutory Requirements for EHB Coverage

The EHBs are mandated in Section 1302 of the ACA. It is critical that the final regulations on EHB benchmark plans explicitly establish appropriate coverage of these benefits in a manner that is consistent with the statute and the needs of adults and children with disabilities. The statutory mandate to cover these essential health benefits while ensuring that benefit design is non-discriminatory based on disability are important guardrails the final rule must respect.

We believe an EHB regulation that does not ensure appropriate coverage of essential health benefits would be in conflict with the letter and the spirit of the law. These legal parameters also

mean that people with disabilities and chronic conditions who need services and devices should not face unreasonably restrictive coverage policies or arbitrary constraints that hinder their ability to achieve results through appropriate treatment.

Non-discrimination Provisions of the ACA

We take this opportunity to encourage CMS to actively monitor whether States comply with the key non-discrimination portions of the ACA to ensure that health plan benefit designs do not discriminate. The ACA requires that benefit design not discriminate against individuals because of their age or disability.⁴ There are numerous legal protections in the ACA that are designed to ensure fairness and equity in the benefit design of the EHB package. These provisions include the prohibition against discrimination based on health status or disability⁵, as well as the general non-discrimination section of the law found at Section 1557 of the ACA. These provisions also include the requirement that the Secretary must ensure that essential benefits reflect an “appropriate balance” of benefits covered across categories⁶, that there is parity across the categories of benefits⁷, and that the Secretary must not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of disability.⁸

Further, the Secretary must take into account the health care needs of diverse segments of the population, including children, persons with disabilities, and other groups.⁹ This language speaks directly to the need to include in the EHB package services and devices such as rehabilitation. In addition, the Secretary must ensure that EHBs are not subject to denial to individuals against their wishes on the basis of the individual’s present or predicted disability, degree of medical dependency, or quality of life.¹⁰ CCD urges CMS to reiterate these requirements in the final rule so that states are clear that they must continue to meet these protections when designing EHB benchmark plans.

While CCD understands that CMS will rely on states to monitor these areas, we believe that there is an ongoing federal role, which does not conflict with or impede a state in exercising its role, in regulating health insurance markets. This is particularly important in avoiding discrimination based on an individual’s underlying medical condition.

IV. Provider Network Adequacy

The adequacy of a plan’s provider network can impact the level of access to benefits for enrollees. CCD has concerns, outlined below, about network adequacy under CMS’s proposal to grant the states a larger role in the QHP certification process. CCD urges CMS to ensure that, if states are given a larger role in the QHP certification process, state review processes are sufficient to ensure that network adequacy standards safeguard access to a range of physically

⁴ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302(b)(4)(B) (2010).

⁵ *Id.* § 1201.

⁶ *Id.* § 1302(b)(4)(A).

⁷ *Id.*

⁸ *See id.* § 1302(b)(4)(B).

⁹ *See id.* § 1302(b)(4)(C).

¹⁰ *See id.* § 1302(b)(4)(D).

accessible, qualified providers across primary care, specialties, and subspecialties, without the burdens of significant travel distances and long waiting times. In addition, CMS must ensure that these standards are enforceable.

Under the Proposed Rule, states would have a larger role in the QHP certification process. CMS proposes that, starting in plan year 2019, the FFEs and SBEs on the Federal platform (SBE-FPs) rely on State reviews of network adequacy standards where the States have been determined to have an adequate review process. CMS also proposes to eliminate requirements for SBE-FPs to enforce FFE standards for network adequacy (42 C.F.R. § 156.230). Instead, SBE-FPs would have the flexibility to determine how to implement the network adequacy standards with which issuers must comply.

For QHP enrollees to benefit from appropriate rehabilitation, we believe that QHPs sold through the exchanges must adhere to patient-friendly network adequacy standards that provide ample access to the full complement of rehabilitation and habilitation service and device providers, professionals, and facilities that provide both primary and specialty care. These services should be provided based on the individual's needs, prescribed in consultation with an appropriately credentialed clinician, and based on the assessment of an interdisciplinary rehabilitation or habilitation team and resulting plan of care.

In addition to physically accessible primary care, such provider networks should include physician specialty services such as physical medicine and rehabilitation, neurology, orthopedics, rheumatology, and many other subspecialties, including physicians serving pediatric populations. They should include post-acute rehabilitation programs such as inpatient rehabilitation hospitals and units (IRFs), skilled nursing, home health, and home and community based services. They should also include physical, occupational, and speech-language therapy, audiology services, and recreational and respiratory therapy. Durable medical equipment specialists and appropriately credentialed prosthetists and orthotists must also be included in provider networks as well as clinicians engaged in psychiatric rehabilitation, behavioral health services, cognitive therapy, and providers of psycho-social services provided in a variety of inpatient and/or outpatient settings.

Presently, our members know of many QHP issuers that offer limited provider networks that restrict access to many of these types of providers. CCD supports maintaining and strengthening federal network adequacy standards, and is concerned that a reduced federal role in reviewing network adequacy would only exacerbate this problem. In determining whether a State has an adequate review process for network adequacy standards and whether a State can enforce network adequacy standards in their State, CCD urges CMS to look to whether the State has adopted the following metrics for assessing a QHP's network adequacy:

- *Broad application of time and distance standards.* Network adequacy standards should ensure that persons with disabilities are not burdened by significant traveling distances in order to receive covered services under the plan, and recognize that many people with disabilities lack transportation options. Any assessment of network breadth should be broad enough to account for the medical needs of QHP enrollees residing in rural areas. QHP issuers should be required to collect data on the average time it takes for their

enrollees to secure an appointment with each of their network's providers. Furthermore, we note that time and distance standards should not always be used as the sole measure of network breadth, given shortages of some types of providers and the regionalization of some specialty care.

- *Securing a broad range of providers and access to specialized rehabilitation and habilitation services.* Network adequacy standards must require health plans to have a full range of adult and pediatric providers in-network capable of providing all covered services, from preventative care to the most complex care, such as care provided in an inpatient rehabilitation hospital. Networks should also be able to contract with specialists (adult and pediatric), and those that provide specialized rehabilitation and habilitation services and devices specifically, without additional cost-sharing burden to consumers. In addition to many of the specific types of services already mentioned, these services include: brain injury treatment programs including residential/transitional programs, prosthetists, orthotists, durable medical equipment providers, and providers of complex rehab technology (CRT). Out-of-network exceptions and appeals processes, as well as up-to-date provider directories, are critical to patient access, but they cannot be a substitute for robust provider network standards.
- *Seamless care transitions.* CCD supports an emphasis on seamless care transitions that ensure that enrollees undergoing a course of treatment can continue their relationship with their provider during that treatment episode. Specifically, new enrollees in the midst of an active course of treatment should be able to continue that treatment with their current providers for at least 90 days, even if those providers are not in their new plan's network.
- *Credentialing.* We believe that all providers within networks must be appropriately certified and/or licensed by the appropriate bodies. For example, suppliers without sufficient training, expertise, or credentials should not be permitted to provide highly complex or other specialized rehabilitative or habilitative services and devices that appropriately credentialed providers should be providing. Private accreditation from accreditation agencies that understand rehabilitation and habilitation is a good indicator of quality providers.

People with disabilities should have access to disability-specific specialists and services, in settings that are physically accessible, and with a choice of providers—primary, specialty, and subspecialty—no matter the QHP in which they are enrolled. We believe that the adequacy of a plan's provider network dictates the level of access to benefits otherwise covered under the health plan. If a plan covers a benefit but limits the number of providers or specialists under that plan, coverage will be curtailed through a lack of access to providers with sufficient expertise to treat the patient.

Additionally, network adequacy standards should ensure that persons with disabilities are not burdened by significant traveling distances in order to receive covered services under a plan. In light of these concerns, review processes must ensure robust network adequacy standards and these standards must be strongly enforced. It is essential that Americans have access to

affordable and meaningful coverage of needed services, including disability-specific services such as rehabilitative and habilitative services and devices, mental health, and other benefits, through the private market.

V. Navigator Program Standards

CCD is disappointed at and would urge HHS to retract the proposed changes to reduce the number of required navigator entities in a state from two to one. The requirement to have two entities ensures that a state can have a general entity and one more tailored to specific needs within a state, whether that includes a focus on young adults, individuals with limited English, or other targeted populations. Further, removing the requirement that one entity be a community and consumer-focused, non-profit organization is also troubling. Many of the individuals assisted by navigator entities have complex situations and community and consumer-based entities are best suited to address their needs. They typically have the experience working with these populations on a regular basis.

For a number of important reasons, we do not support the proposal to remove the requirement that a navigator entity maintain a physical presence in the Exchange service area. First, face-to-face assistance is often critical to obtain the trust of applicants and to help walk them through the various components of application, plan selection, resolving data matching inconsistencies, and perhaps assisting with appeals. Further, entities with a physical presence will better know their communities and be better able to serve them because they likely interact with the target populations on an ongoing basis and are able to build relationships that transcend the application process. Physically present entities remain available after open enrollment to provide assistance if questions arise, can assist in finding providers, and can help consumers prepare for re-enrollment.

Navigators perform far more services than enrollment activities alone. Having a community presence and building ongoing relationships with consumers is critical to ensure all eligible consumers obtain and maintain health insurance. In particular, individuals with low health literacy (in addition to low literacy in general), low internet proficiency, and those who live in rural areas may face additional challenges in enrolling and rely on assisters to help complete enrollment. As the proposed rule recognizes in the preamble, “we believe entities with a physical presence and strong relationships in their FFE service areas tend to deliver the most effective outreach and enrolment results.” (81 Fed. Reg. 51084). Given this recognition, it is appropriate to maintain the requirements that a navigator have a physical presence in the state in which it receives funding to assist consumers.

VI. Qualified Health Plan Certification

CCD recognizes that the ACA provides opportunities for state flexibility in some implementation areas. However, that flexibility should not apply to monitoring and enforcing the ACA’s non-discrimination provisions. HHS has previously described a number of plan review and monitoring activities to help determine whether plan benefit designs comply with the ACA non-discrimination provisions. However, in the proposed rule, HHS states that it wishes to streamline

the QHP certification process and further devolve plan review and monitoring to state authorities.¹¹

We urge HHS to employ a broad, multi-prong approach to non-discrimination compliance, monitoring, and enforcement that includes effective methodologies and robust national standards to assess plan benefit design. Reliance on state monitoring and enforcement of non-discrimination protections leads to disparate health care access and quality (e.g., a plan benefit design may be considered compliant by one state but found non-compliant by another state).

The ACA contains additional protections for individuals by barring discriminatory plan benefit design (described above). These protections also establish that a QHP may “not employ marketing practices or benefit designs that *have the effect of discouraging the enrollment in such plan by individuals with significant health needs.*”¹² However, despite the ACA’s robust non-discrimination protections, some QHPs continue to discriminate against individuals with disabilities and those with serious or chronic medical conditions.

For instance, in a study published in the *New England Journal of Medicine* in January 2015, *Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace*, researchers at the Harvard School of Public Health examined 48 ACA health plans and found that a dozen of these plans placed medications used to treat HIV/AIDS in the highest cost-sharing tiers.¹³ This practice — known as “adverse tiering” —serves to discourage people with significant health needs from enrolling in the health plan. Another study identified adverse tiering for medications used in the treatment of mental illnesses in the formularies for 84 health plans.¹⁴ These medications were placed on high cost sharing tiers or were restricted through utilization management tools.¹⁵

Adverse tiering can have serious consequences by impeding access to potentially life-saving medications. Adverse tiering works for insurers by steering persons with significant health needs, such as HIV/AIDS, away from their plans. As a result, plans with more balanced tiering structures become more likely to enroll high-need patients. Consequently, the health plan’s enrollment could become imbalanced, placing pressure on the health plan to change its coverage policies or raise premiums and/or deductibles. This can lead to a “race to the bottom” effect where all or most Marketplace plans start placing these medications in the highest-cost tiers. Meanwhile, people who most need coverage are left with few options.

Adverse tiering, like adverse selection or “cherry picking” healthier enrollees, is prohibited under the ACA. HHS recognized this in previous rulemakings and guidance, most recently in the 2017 Letter to Issuers, stating, “if an issuer places most or all drugs that treat a specific condition on the highest cost formulary tiers, that plan design might effectively discriminate against, or

¹¹ 82 Fed Reg 51109.

¹² 42 U.S.C. § 18031(c)(1)(a) (emphasis added); see also 45 C.F.R. § 156.225(b)).

¹³ Douglas B. Jacobs, Sc.B., and Benjamin D. Sommers, M.D., Ph.D., *Using Drugs to Discriminate – Adverse Selection in the Insurance Marketplace*, *N ENGL J MED* 399-402 (Jan. 29, 2015).

¹⁴ NAMI, *A Long Road Ahead – Achieving True Parity in Mental Health and Substance Use Care* (April 2015) at 7; available at <https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-A-LongRoadAhead.pdf>.

¹⁵ *Id.*

discourage enrollment by, individuals who have those conditions.”¹⁶ In the 2018 Letter to Issuers, HHS reiterates its concern about adverse tiering and proposes to review tiering of drugs used in the treatment of high-cost, chronic medical conditions.¹⁷

Compliance reviews serve an important role in ensuring that issuers meet EHB and other standards. CCD strongly supports strengthening the compliance review process and allowing for sanctions on issuers that are non-responsive or uncooperative with the compliance reviews. We also urge HHS to make the results of its compliance reviews publicly available on an ongoing basis rather than posting a year-end summary report.¹⁸ Health care consumers and advocates could greatly benefit from more detailed information revealed by compliance reviews when assessing plan performance, including issuers and plans subject to targeted, expedited reviews when HHS has identified potential harm to consumers.

HHS has made tremendous progress establishing tools and guidance to review plans for compliance with non-discrimination protections. We oppose efforts to weaken those standards and monitoring efforts. The Consortium for Citizens with Disabilities Health Task Force greatly appreciates your attention to our concerns involving this important proposed rule. Should you have further questions regarding this information, please contact the co-chairs of the CCD Health Task Force.

Sincerely,

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¹⁶ CCIIO, 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 29, 2016) at 45; *available at* <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf>.

¹⁷ CCIIO, 2018 Letter to Issuers in the Federally-facilitated Marketplaces (Dec. 16, 2016) at 46; *available at* <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>.

¹⁸ 2017 Letter to Issuers at 60, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf>; 2018 Letter to Issuers at 43, <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces.pdf>.