COALITION FOR WHOLE HEALTH

March 7, 2017

Patrick Conway
Acting Administrator
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W. Room 445 –G
Washington, D.C. 20201

RE: Proposed Rule: Patient Protection and Affordable Care Act; Market Stabilization (CMS 9929-P)

Dear Mr. Conway:

The Coalition for Whole Health (CWH) is a broad coalition of local, State, and national organizations in the mental health and substance use disorder (MH and SUD) prevention, treatment, and recovery communities. Thank you for the opportunity to submit comments on the proposed rule on behalf of the Coalition and the individuals with MH and SUD whose health care has been enhanced by strong patient protections in the individual and group markets.

The CWH's comments address the proposed revisions to the open and special enrollment standards, and the network adequacy and essential community provider (ECP) standards. As set out below, the CWH opposes the proposed shortening of the open enrollment period, heightened verification requirements for persons eligible for special enrollment, and limitations on plan selection for those eligible for special enrollment. In addition, the proposed retreat from federal oversight of carrier compliance with network adequacy standards and current essential community provider requirements will undermine access to substance use and mental health care treatment at a time when all states are struggling to address the worst opioid epidemic in history.

Although we appreciate the opportunity to provide comment, we are very concerned that the Administration's decision to only provide a 20-day comment period for this proposed rule made it difficult for many consumers, providers, and other stakeholders to meaningfully comment on the proposals included in the rule. Past opportunities to comment have typically offered 30, 60-, or 90-day comment periods. This short timeframe provides affected stakeholders inadequate time to fully analyze the rule and offer important comprehensive recommendations. We urge the Administration to provide comment periods of at least 30 days for future proposed rules of this significance.

I. Open Enrollment

The CWH opposes plans to shorten the annual open enrollment period. While we recognize a shorter enrollment period was planned for 2018, given all the potential changes that consumers have to digest this year, we believe that keeping a longer open enrollment period would be beneficial to consumers as well as issuers. We believe the benefits – enrolling more consumers –

outweigh the perceived costs of having consumers enroll for less than a full year (if they enroll after December 15). We also are concerned about the proposed shortened enrollment period due to the added burdens it will put on navigators and assisters. Many navigators and assisters already work long hours and weekends throughout the current open enrollment period to meet the increased demand. Shortening the period will make it even more difficult to reach and serve all consumers.

We support CMS's plan "to conduct extensive outreach to ensure that all consumers are aware of this change and have the opportunity to enroll in coverage within this shorter time frame." However, we seek clarity on what exactly will be included in this outreach. In looking at the effect of the current Administration's scaling back outreach and advertisements in the final two weeks of the fourth open enrollment period, it is clear that outreach and education have a profound and positive impact on enrollment. We also urge CMS to continue to provide Navigator grant funding at levels that are comparable to prior years, since consumers enrolling with the help of in-person assisters are nearly twice as likely to successfully enroll as those enrolling online without help. We also strongly recommend that HHS not require state-based marketplaces to adhere to a shorter enrollment period. The state-based marketplaces are in the best position to determine their own enrollment periods which may factor in state-specific issues.

II. Special Enrollment

Special Enrollment Periods (SEPs) have been an important consumer protection to ensure access to health insurance following a significant life event or evidence of extenuating circumstances that prevented enrollment during the open enrollment period. Absent evidence of abuse (which has not been documented or shown), we do not support proposals that seek to limit availability of SEPs. The CWH urges HHS to maintain current SEP application and verification standards. Creating burdensome documentation requirements before someone may enroll in a plan will only serve as an enrollment barrier for individuals who have in fact had a qualifying life event. The current standards, which allow consumers to receive coverage while documentation of eligibility is reviewed, should be left in place.

In particular, we oppose the proposal to prohibit individuals from changing metal levels mid-year when they experience a qualifying life event and SEP. An SEP resulting from the addition of a dependent through marriage, birth, or adoption, for instance, should allow a consumer to review if another plan and metal level makes more sense. Consumer choice during SEPs is a common industry practice in the employer-sponsored coverage market and is an important consumer protection that ensures individuals and families are enrolled in the plans that are right for them and that are affordable. We also oppose the addition of continuous coverage requirements as a pre-condition of SEP availability in certain instances. Life circumstances will inevitably sometimes result in gaps in health insurance coverage, particularly for lower income individuals. This should not preclude individuals from being able to enroll in an SEP when they meet all other criteria.

III. Network Adequacy

The CWH opposes the proposed standards that would transfer responsibility for network adequacy review of qualified health plans (QHPs) from CMS to the States or, alternatively, to accreditation entities in States without the authority or capacity to conduct sufficient network adequacy reviews. In addition, the proposed rule would replace the time and distance criteria applied in 2017 QHP review and proposed for 2018 plan review (*see* 2018 Letter to Issuers In Federally-Facilitated Marketplaces, at 23-25, Dec. 16, 2016) with either (1) the criteria a state chooses to use under a "reasonable access standard," (2) those of the plan's accrediting body, or (3) for unaccredited issuers, access plan standards that are consistent with the National Association of Insurance Commissioners' Health Benefit Plan Network Access and Adequacy Model Act. The 2018 standards, set out in the Issuer Letter, would require carriers to meet specific travel time and distance standards for mental health and substance use disorder services as well as other critical services for persons with these health conditions. Id. at 24-25.

We oppose the proposed standard as it eliminates all efforts to standardize network adequacy requirements across States and QHPs. A review of State network adequacy standards, in effect as of August 2016, compiled by the University of Maryland Carey School of Law, Drug Policy and Public Health Strategies Clinic,[1] found that only twelve (12) states have adopted both quantitative travel time and distance standards to assess network adequacy.[2] Seven (7) states have adopted only distance requirements[3] and two (2) states have only travel time requirements.[4] The remaining twenty-nine (29) states and the District of Columbia do not have quantitative geographic standards that allow for consistent assessment of QHP network adequacy, as contemplated under the 2018 Issuer Letter.[5] For those with quantitative geographic standards, the state-specific standards vary considerably and do not necessarily cover all of the specialties or the minutes/miles criteria that CMS has determined to be necessary to address historical gaps in network adequacy.

The review of State network adequacy standards raises particular concerns for CWH because only ten (10) states have adopted or require geographic criteria specific to mental health and substance use disorder providers.[6] Reliance on States to assess "reasonable access" based on their existing standards will not ensure that consumers have access to critical behavioral health services, as required under § 156.230(a)(2). Prompt access to behavioral health care is needed now more than ever to respond to our nation's opioid epidemic.

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[1] Fifty State Survey Network Adequacy Quantitative Standards: Geographic Criteria, Appointment Wait Times & Provider/Enrollee Ratios (Current through August 2016). Available on file at the Legal Action Center.

[2] Arizona, California, Kentucky, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Tennessee and Washington.

[3] Alabama (HMO plans), Arkansas, Colorado, Delaware, Missouri (HMO plans), Montana, and Texas.

[4] Florida (HMO plans) and Vermont.

[5] Twelve states have also adopted appointment wait time standards, which is an important measure of network adequacy and would presumably be used to assess QHP networks. Arizona, California, Colorado, Florida (HMO plans), Maine, Missouri (HMO plans), Montana, New Jersey, New Mexico, Texas, Vermont and Washington. All but one of these states – Maine – also have geographic standards.

[6] Two additional states – Maine and Texas – have adopted wait time standards for mental health and substance use disorder services that would be used to assess QHP networks.

For states that lack the authority or capacity to conduct network adequacy reviews, reliance on the accreditation process is no substitute for objective and uniform standards that apply to all QHPs in the FFM. Consumers do not have ready access to plan accreditation standards, and they cannot enforce those standards.

The elimination of uniform network adequacy standards for MH, SUD and other medical services will also undermine consumer confidence that their plans will provide access to services through network providers. The proposed rule recognizes the need to stabilize the market through increased enrollment of younger individuals. Insurance coverage will be less attractive to individuals of all ages if network adequacy becomes less robust, as they will have no guarantee of access to affordable care at a time of need.

Finally, the proposed retreat from an assessment of uniform quantitative standards is contrary to the recommendations of the National Association of Insurance Commissioners' Health Benefit Plan Network Access and Adequacy Model Act and may discourage States from adopting quantitative network adequacy standards that will help regulators determine whether carriers meet the reasonable access standard. While NAIC's Model Act does not adopt specific network adequacy standards, the drafters emphasize that [s]ome states have developed specific quantitative standards [in law and regulation] to ensure adequacy access that carriers must, at a minimum, satisfy in order to be considered to have a sufficient network." (Model Act, Network Adequacy, Section 5(B) Drafting Note at 74-8). Insurance departments will be hard-pressed to determine network sufficiency, consistent with the Model Act, without quantitative standards. As noted above, the proposed rule will undermine CMS's response to evidence of inadequate network and proposals to develop even more rigorous standards that protect consumers and increase confidence in their ability to gain access to care that they need and are paying for.

IV. Essential Community Provider

The CWH opposes the proposal to reduce the percentage of essential community providers (ECPs) with which a plan is required to contract from 30% of available ECPs in each plan's service area to 20% of available ECPs. The overwhelming majority of plans – 94% - met this standard in 2017, and there is no evidence that plans would have difficulty doing so in 2018.

ECPs serve a critical role in the health care of lower income individuals with mental health and substance use disorders and other chronic health conditions. Historically, these individuals have received treatment in community-based treatment programs, and they look to these programs for continuity of care and linkages to primary and other health services as they move between the public and private insurance systems. By allowing carriers to contract with far fewer ECPs, many individuals will face the difficult choice of either disrupting their care with a trusted health care provider or, to the extent feasible, paying substantially more to continue care with their non-network provider.

The proposed revision to the ECP standard also sends the wrong message to States that are exploring standards that will boost ECP requirements to respond to local needs. For example, community-based substance use treatment programs are not included in the definition of ECP,

even though they serve the population served by these providers. We are aware of State Exchanges that have expanded the ECP definition to include community-based substance use treatment programs to address the opioid epidemic. A retreat from the existing federal standard may make it more difficult to retain and expand such standards.

As States battle the escalating opioid and suicide epidemics, we cannot afford to make health care less available for individuals with mental health and substance use disorders. The health care needs of vulnerable individuals certainly outweigh the minimal burden on carriers that would be required to submit a justification of sufficient number and geographic distribution of ECPs.

Finally, we do not object to allowing a carrier to include ECP write-ins for satisfaction of the ECP standard and consistent with the proposed requirements.

We greatly appreciate your careful consideration of our comments. We strongly support the goals of ensuring that all Americans have access to high-quality, affordable health care, including comprehensive care for mental health and substance use disorders and look forward to working with you.

Please contact us if you have any questions or if we can be of further assistance.

Sincerely,

Ron Manderscheid and Paul Samuels, Co-Chairs
The Coalition for Whole Health