May 6, 2019

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: **Patient Protection and Affordable Care Act; Increasing Consumer Choice Through the Sale of Individual Health Insurance Coverage Across State Lines Through Health Care Choice Compacts**

Dear Administrator Verma:

The undersigned members of the Coalition to Preserve Rehabilitation ("CPR") appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services ("CMS") request for information ("RFI") regarding the sale of individual health insurance across state lines.[1] CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.

CPR shares CMS's goal of increasing access to affordable health care, but we are concerned that CMS's proposal to expand the sale of health insurance across state lines would leave adults and children, particularly those with disabilities and chronic health conditions, with less comprehensive coverage, limited or no in-network access to specialized care providers, and higher out-of-pocket costs. It is of utmost importance that qualified health plans ("QHPs") do not provide a false sense of health insurance coverage by offering minimal benefits in exchange for lower premiums. This comment letter will focus largely on access to rehabilitation services and devices, as well as provider network adequacy requirements and other provisions that impact individuals with disabilities.

I. Health Care Choice Compacts (Section 1333 of the ACA)

In the RFI, Health Care Choice Compacts ("HCCCs") implemented under Section 1333 of the Affordable Care Act ("ACA") are the primary mechanism through which CMS seeks to expand the

[1] Patient Protection and Affordable Care Act; Increasing Consumer Choice Through the Sale of Individual Health Insurance Coverage Across State Lines Through Health Care Choice Compacts, 84 Fed. Reg. 8,657 (Mar. 11, 2019).

ability of issuers to sell insurance across state lines. Section 1333 of the ACA authorizes CMS to implement a regulatory framework that allows two or more states to enter into a HCCC.[2] Under a HCCC, a health insurance issuer can offer one or more QHPs in the individual health insurance market in any state included in the HCCC. In order to enter into a HCCC, a state must pass legislation specifically authorizing it to do so and the HCCC must be approved by CMS.

As CMS notes in the RFI, to date, no states have entered into a HCCC. Despite having been the law for almost 10 years, states have not gravitated toward this approach or pursued the sale of insurance across state lines through a HCCC in any meaningful way, indicating that this is not a fruitful practice to pursue. In addition, despite the fact that four states (Georgia, Maine, Oklahoma, and Wyoming) have passed laws authorizing the sale of health insurance coverage across state lines in certain circumstances, no health insurance issuers appear to be selling health insurance coverage across state lines under these laws. The lack of engagement in the cross-state sale of insurance under these existing laws is further evidence that CMS's pursuit of this policy proposal is not a practical approach to increasing access to affordable health care.

II. Access to Rehabilitation Services and Devices

If CMS decides to pursue the sale of insurance across state lines through HCCCs, CPR has significant concerns about the impact of this proposal on access to rehabilitation services and devices under the essential health benefit ("EHB") category of rehabilitative and habilitative services and devices, as well as network adequacy, transparency, and dispute resolution with out-of-state issuers. These concerns are described in detail below.

a. The Importance of Rehabilitation Services and Devices

Rehabilitation services and devices are 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 and devices are closely related to habilitation services and devices, which focus on skills and functions that were never acquired due to a disabling condition. Rehabilitation services and devices are essential to enabling 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;
- Engage in work, family, and community activities as much as possible;
- Avoid unnecessary and expensive re-hospitalization and nursing home placement; and
- Prevent secondary medical conditions.

The services and devices in the rehabilitation benefit category 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

[2] 42 U.S.C. § 18053(a). As CMS notes in the RFI, the statute requires CMS, in consultation with the National Association of Insurance Commissioners, to issue regulations implementing this provision no later than July 1, 2013; however, CMS has not yet promulgated any regulations implementing Section 1333 of the ACA.

and/or outpatient settings, as well as durable medical equipment, prosthetic limbs, orthopedic braces, and medical supplies.

The ACA includes statutory language that requires coverage of EHBs, including one of ten categories of benefits known as "rehabilitative and habilitative services and devices." Inclusion of this language in the statute was a major milestone for the rehabilitation and disability community in that Congress recognized the importance of these benefits to improve the health and functioning of the American people. In the February 2015 Notice of Benefit and Payment Parameters Final Rule,[3] CMS defined "rehabilitation services and devices" as follows:

> "Rehabilitation services and devices—Rehabilitative services, including devices,…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."

For the first time, this regulation established a uniform definition of rehabilitation 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 definition includes both rehabilitative *services* and rehabilitative *devices*. The adoption of a federal definition of rehabilitation services and devices minimized the uncertainty in coverage for children and adults in need of medical rehabilitation and post-acute care.

There is a compelling case for coverage of both rehabilitation and habilitation 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 a profound impact on the ability to perform activities of daily living in the most independent manner possible. Rehabilitation services and devices are highly cost-effective and decrease downstream costs to the health care system for unnecessary disability and dependency.

b. Impact of the Sale of Insurance Across State Lines on Access to Rehabilitation Services and Devices

In the RFI, CMS specifically asked about the impact of the sale of insurance across state lines on individuals with disabilities and chronic conditions:

> To what extent, if any, would the sale of individual health insurance coverage across state lines pursuant to a Health Care Choice Compact positively or negatively impact the following populations: persons with pre-existing conditions; persons with disabilities; persons with chronic physical health conditions; expectant mothers; newborns; American Indians and Alaska Natives and tribal entities; veterans; and persons with behavioral health conditions, including both mental health and substance use disorder conditions?[4]

CPR has significant concerns that the sale of insurance across state lines is simply a method of reducing the cost of insurance by allowing the sale of bare bones coverage that prevents unsuspecting enrollees from accessing benefits when they need them. As explained above, rehabilitation services

[3] 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).
[4] Patient Protection and Affordable Care Act; Increasing Consumer Choice Through the Sale of Individual Health Insurance Coverage Across State Lines Through Health Care Choice Compacts, 84 Fed. Reg. 8,657, 8,660 (Mar. 11, 2019).

and devices are critically important for individuals with disabilities and chronic conditions. Any reduction in coverage of this benefit category due to a reduction in overall benefit coverage resulting from the sale of insurance across state lines would have a serious negative impact on individuals with disabilities and chronic conditions.

While the statute requires that issuers still be subject to certain laws and regulations of the state in which an enrollee resides (such as network adequacy and consumer protection standards),[5] issuers would not be required to comply with the benefit coverage requirements of the enrollee's state. As a result, CPR has significant concerns that issuers and consumers would gravitate toward the least comprehensive and least expensive plans, thereby creating a "race to the bottom" in terms of benefit coverage, particularly in the area of rehabilitation.

A reduction in coverage of rehabilitation services would not significantly decrease the cost of insurance packages overall, but would lead to very high increases in out-of-pocket costs for children, families, and adults who need this type of care. Pursuing policies that may reduce coverage of these services for people with disabilities or chronic conditions is not cost-effective in the long term as it often results in further complications and avoidable hospital admissions and readmissions, as well as unnecessary dependency and disability.

In addition, despite the fact that the statute requires issuers to comply with the network adequacy laws and regulations of the state in which an enrollee resides, CPR still has significant concerns regarding the ability of out-of-state issuers to adhere to patient-friendly network adequacy standards. Such networks must provide ample access to the full complement of providers of rehabilitation services and devices, as well as professionals and facilities that provide both primary and specialty care. Services should be provided based on the individual's needs, prescribed in consultation with an appropriately credentialed clinician, and based on an assessment by an interdisciplinary rehabilitation team and resulting plan of care. In addition to physically accessible primary care, such provider networks should include (but not be limited to):

- Physician specialty services such as physical medicine and rehabilitation, neurology, orthopedics, rheumatology, and many other subspecialties, including physicians serving pediatric populations;
- Post-acute rehabilitation programs such as inpatient rehabilitation hospitals and units, skilled nursing, home health, and home and community based services;
- Durable medical equipment specialists and appropriately credentialed prosthetists and orthotists;
- Clinicians engaged in psychiatric rehabilitation, behavioral health services, cognitive therapy, and providers of psycho-social services provided in a variety or inpatient and/or outpatient settings.

Presently, our members know of many issuers that offer limited provider networks that restrict access to these necessary types of providers. 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

[5] 42 U.S.C. § 18053(a)(1).

significant traveling distances in order to receive covered services under a plan. CPR is concerned that out-of-state issuers would face significant challenges in establishing provider networks that meet these standards, thus exacerbating the problem of lack of access to rehabilitation services and devices.

Finally, while the statute does require that issuers notify policyholders that their coverage may not otherwise be subject to the laws of the state in which the policyholder resides,[6] CPR has serious concerns that a purchaser may not be aware that an out-of-state plan does not cover benefits mandated by their state. This would potentially leave policy holders unaware that they have inadequate coverage when they need it most, resulting not only in reduced access to care, but also higher out of pocket costs.

CPR is also concerned that consumers dealing with health plans based in one state providing coverage for care in another state may have difficulty resolving disputes under their insurance contracts. As discussed in this comment letter, rehabilitation services and devices are highly cost-effective and decrease downstream costs to the health care system and society at large for unnecessary disability and dependency. For these reasons, it is essential that any regulatory framework for the sale of insurance across state lines be transparent about access to the full continuum of rehabilitation care.

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CPR shares CMS's goal of reducing the costs of health care and promoting competition in the marketplace. However, CPR has significant concerns that CMS's proposals in this RFI would reduce access to certain EHBs, such as rehabilitative and habilitative services and devices. CPR urges CMS to pursue policies that preserve access to rehabilitation services and devices in order to reduce costs to the health care system and ensure that children and adults can maximize their health and independent function through access to these services.

We greatly appreciate your attention to our comments on the proposals in this RFI. Should you have further questions regarding this information, please contact Peter Thomas, coordinator of CPR by e-mailing Peter.Thomas@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
America Spinal Injury Association (ASIA)
American Academy of Physical Medicine and Rehabilitation
American Association of People with Disabilities
American Association on Health & Disability
American Heart Association
American Medical Rehabilitation Providers Association
American Physical Therapy Association
Amputee Coalition
Association of Academic Physiatrists
Association of Rehabilitation Nurses

[6] 42 U.S.C. § 18053(a)(1)(B)(iii).

Brain Injury Association of America
Center for Medicare Advocacy
Christopher & Dana Reeve Foundation
Clinician Task Force
Disability Rights Education and Defense Fund
Easterseals
Falling Forward Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of Social Workers (NASW)
National Athletic Trainers' Association
Paralyzed Veterans of America
United Spinal Association