March 2, 2020

VIA ELECTRONIC SUBMISSION

The Honorable Alex Azar
Secretary, U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

RE: Public Comments on Notice of Benefit and Payment Parameters for 2021 (RIN 0938–AT98, CMS–9916–P)

Dear Secretary Azar:

The undersigned members of the Habilitation Benefits (HAB) Coalition appreciate the opportunity to comment on the Department of Health and Human Services' (HHS) proposed rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021[1] (the Proposed Rule).

The HAB Coalition is a group of national nonprofit consumer and clinical organizations focused on securing and maintaining appropriate access to, and coverage of, habilitation benefits within the category known as "rehabilitative and habilitative services and devices" in the EHB package under the Patient Protection and Affordable Care Act (ACA), Section 1302.

The Proposed Rule sets forth benefit and payment parameters, changes the automatic enrollment process, clarifies EHB Benchmark Plan defrayal policies, expands special enrollment periods, and sets out many other policies implementing the ACA. This comment letter will focus on key proposed provisions relating to enrollees in need of habilitative services and devices, one of the categories of essential health benefits under the ACA.

I. Habilitative Services and Devices under the Affordable Care Act

Prior to the ACA, most private health plans did not cover habilitative services and devices and only three states (Illinois, Maryland, and Oregon) had adopted a habilitative services coverage mandate in the individual market. Not only did this dramatically impact access to and quality of care for children and adults in need of these services and devices, but a lack of coverage also contributed to significant downstream costs to the health care system for unnecessary disability

[1] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021, 85 Fed. Reg. 7088 (Feb. 6, 2020). Available at: https://www.federalregister.gov/documents/2020/02/06/2020-02021/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021.

and dependency. Therefore, coverage gains for habilitation services and devices were hard fought but necessary to meet the needs of a wide variety of children and adults with autism, cerebral palsy, congenital deficits, disabilities, and other chronic and progressive conditions.

The category of "rehabilitative and habilitative services and devices" was included in the ACA as an essential health benefit, one of ten essential categories of benefits that must be covered by ACA health plans. It is noteworthy that Congress chose to include a separate EHB category for rehabilitative and habilitative services and devices to specifically list in the statute in recognition of the important role the benefit plays in helping ensure that adults and children maximize their health, function, ability to live independently, and participation in society. In the February 2015 Notice of Benefit and Payment Parameters Final Rule[2], 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."

The inclusion in the ACA of the category of rehabilitative and habilitative services and devices 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, regardless of the diagnosis or reason for one's functional impairment. The federal coverage standard for habilitation benefits has been responsible for a dramatic increase in access to these important benefits for patients across the country.

II. Changes to the Automatic Enrollment Process under the Proposed Rule

In the Proposed Rule, CMS proposes to end the automatic enrollment process for individuals who qualify for $0 premium plans as a result of advance premium tax credits. The HAB Coalition urges CMS to encourage individuals to take an active role in their coverage options, instead of instituting measures that have the effect of driving individuals out of the private insurance market, thereby increasing premiums for those who remain.

This change follows this administration's previous reductions to Navigator funding, which decreased the education and outreach services available to consumers. We are concerned that these steps tend to punish individuals who have qualified for $0 premium plans by driving up premiums, ultimately resulting in more individuals leaving the health care marketplace. As these individuals cannot turn to Medicaid, this proposed change would lead to more individuals being uninsured. In a prior CMS analysis for plan year 2020, CMS stated that the automatic enrollment process was designed to "promote continuity of coverage, support a stable risk pool,

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[2] 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).

and limit administrative burden for enrollees, issuers, and Exchanges."[3] We feel these benefits of automatic enrollment apply equally today and, therefore, we oppose restricting the re-enrollment process as envisioned by the proposed rule, as well as any modification that would unnecessarily reduce coverage.

We strongly oppose CMS finalizing this proposal to change the automatic enrollment process. However, if CMS insists finalizing it, the HAB Coalition urges CMS to institute a three-month grace period from the time an individual is notified of the premium increase. Under this proposal, enrollees would be automatically enrolled in the same qualified health plan at a higher premium and would be notified by CMS of this change. The enrollee would then have three months to log on to HealthCare.gov to re-qualify for a $0 premium plan using advance premium tax credits. This three-month grace period would allow HHS to conduct consumer outreach and education to alert consumers about the new process. The grace period would also alleviate some of CMS' prior concern with the current automatic enrollment process. This grace period suggestion is a secondary alternative if CMS moves forward with this flawed proposal despite the clear impact on health care coverage for American consumers.

CMS explained in the proposed rule that introducing a requirement to take active steps to maintain enrollment would stress administrative systems to the point where consumers would be unable to re-enroll by the December 15 deadline due to high traffic volume.[4] While the HAB Coalition believes the grace period would be a more effective alternative to CMS' proposal, we reiterate our overall concern about modifying the re-enrollment process without a sound basis for doing so. Enrollees have grown accustomed to current marketplace functionality and its many requirements. We expect that the most vulnerable individuals, including those with disabilities and chronic conditions, will be seriously impacted by CMS' proposal as they leave the health care marketplace.

III. EHB Benchmark Plan Defrayal under the Proposed Rule

While the HAB Coalition does not offer specific comments on the proposed state reporting requirements surrounding defrayal at this time, we would like to reaffirm the importance of a standardized habilitation benefit. We believe that the habilitation benefit is simply too important to children and adults with disabilities and chronic conditions to give states the flexibility to possibly limit or otherwise reduce these benefits. This is a statutory benefit that should be as uniform as possible throughout the country, so that access to habilitation benefits does not depend on the state in which one resides.

The HAB Coalition believes that the federal government must play a strong role in the enforcement of the EHB package, particularly when certain EHB benefits, such as habilitative services and devices, are not well understood and have been addressed inconsistently by states. Habilitation services and devices are highly cost-effective and decrease downstream costs to the

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[3] Centers for Medicare and Medicaid Services, *Key 2020 Payment Notice Issues* (Aug. 29, 2018). Available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/August%202018%20Verma%20Azar%20Memo.pdf.

[4] *Id.*

health care system and society at large for unnecessary disability and dependency. They are critical to the ability of children, in the long-term, and adults, in the shorter term, to be healthy, functional and contributing members of society. We urge CMS to reemphasize the following requirements and principles to the states with regard to EHB benchmark plan design:

- The ACA statutory language requires the EHB package to include coverage of both habilitation services *and* devices.
- The uniform definition of habilitative *services* and *devices* serves as a minimum standard for covering habilitative services.
- Limitations in habilitation benefits of any kind should be based on the best available evidence and such decisions should be made by professionals with sufficient knowledge and expertise in the habilitative field to render informed decisions.
- The extent of coverage of habilitative services and devices should at least be in parity with rehabilitative coverage; if service caps in benefits are employed, there must be separate caps for habilitation and rehabilitation benefits.
- Habilitative services and devices should be covered without arbitrary restrictions and caps that limit the effectiveness of the benefit and undercut the ACA's prohibition on lifetime and annual limits in benefits.
- Regardless of the diagnosis that leads to a functional deficit in an individual, the coverage and medical necessity determination for habilitative services and devices should be recommended based on clinical judgment of the effectiveness of the therapy, service, or device to address the deficit.
- Benefits cannot be defined in such a way as to exclude coverage for services based upon age, disability, or expected length of life—an explicit requirement included in the ACA.

In the Proposed Rule, CMS also reiterates its policy that states must adopt new habilitative services mandates through the EHB-benchmark plan process, or risk being subject to the requirement to defray costs. The HAB Coalition opposes any requirements that discourage states from expanding the habilitation benefit, including only allowing states to do so through the EHB benchmark plan process. Instead, we encourage CMS to affirmatively incentivize states to bolster and improve their habilitative services requirements.

IV. Expanding Special Enrollment Periods under the Proposed Rule

The HAB Coalition supports CMS expanding the special enrollment periods under the Proposed Rule. We understand CMS' concern of enrollees using the special enrollment process to change qualified health plan metal tiers depending on their health needs throughout the year. However, the proposed additional special enrollment periods allow enrollees to maintain health care coverage to the maximum extent possible, while minimizing this concern. We believe this provision will help ensure that enrollees have access to affordable, comprehensive health care coverage.

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We greatly appreciate your attention to our comments on this proposal. Should you have further questions regarding this information, please contact Peter Thomas or Joe Nahra, coordinators for the HAB Coalition, by e-mailing Peter.Thomas@PowersLaw.com or Joseph.Nahra@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Habilitation Benefits Coalition

ACCSES
American Association on Health and Disability
American Cochlear Implant Alliance
American Music Therapy Association
American Network of Community Options and Resources
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
The Arc of the United States
Brain Injury Association of America
Christopher and Dana Reeve Foundation
Clinician Task Force
Family Voices
Lakeshore Foundation
Lutheran Services in America – Disability Network
National Association for the Advancement of Orthotics and Prosthetics
National Association of Councils on Developmental Disabilities
National Association of County Behavioral Health and Developmental Disability Directors
National Association for Rural Mental Health
United Cerebral Palsy
United Spinal Association