

March 3, 2017

The Honorable Tom Price, M.D.  
Secretary of Health and Human Services  
Department of Health and Human Services  
200 Independence Avenue SW  
Washington, D.C. 20201

**Re: Comments on Patient Protection and Affordable Care Act; Market Stabilization  
Proposed Rule  
CMS-9929-P**

Dear Mr. Secretary,

On behalf of the more than 50 million adults and almost 300,000 children in the United States with doctor-diagnosed arthritis, the Arthritis Foundation welcomes the opportunity to comment on the *Patient Protection and Affordable Care Act; Market Stabilization Proposed Rule*. As you know, arthritis is a complex, chronic disease that can be difficult to treat, and people who suffer from the disease require regular, on-going care. As a patient advocacy organization, we value our role in helping policy-makers understand the nuanced nature of arthritis treatment and the needs of people who suffer from this disease. Our comments reflect the health care experiences of our constituents and the protections that are most important to help them maintain access to the treatments they need to live a full life. Below please find our comments on the proposed rule.

**Open Enrollment**

The Arthritis Foundation is opposed to Department of Health and Human Services (HHS) shortening the length of the open enrollment period. Centers for Medicare & Medicaid Services (CMS) enrollment data clearly shows that nearly 700,000 people enrolled in the Federal Exchanges in the last week of 2016 enrollment. We recognize that HHS's goal in limiting the enrollment period is to have enrollees begin their coverage period January 1, but we urge HHS to consider the unintended consequences of time limits. People with arthritis have very complicated and nuanced care needs, and we believe a month and a half is not enough time for enrollees with complex care conditions to make a plan selection. Our patient population often has to weigh many factors before choosing a plan that will meet their healthcare needs, including formulary coverage, provider network adequacy and many out-of-pocket cost considerations, from deductibles to co-pays and specialty drug tier co-insurance requirements. Through surveys and focus groups, The Arthritis Foundation has learned from our patient population that they feel they do not have sufficient resources to make fully-informed health plan decisions, and often have difficulty getting adequate information from insurers. Further, patients often rely on caregivers or family to assist in plan selection. HHS should work to ensure enrollees are notified

in timely manner, with clear language of any changes in the marketplace. We ask that HHS maintain the current open enrollment period for the 2018 plan year to allow sufficient time to plan and implement any changes in future years. If the open enrollment period is reduced, we urge HHS to provide patients with personalized resources like Navigators and on-line tools to make well-informed health plan decisions. Further, HHS should work with stakeholders like patient organizations on how to best communicate open enrollment information to patients.

To ensure enrollees can make the best health plan decisions, the Arthritis Foundation urges HHS to ensure tools for consumers are transparent, user-friendly, up to date and available to both current and prospective enrollees. On-line tools like cost calculators should be available to allow enrollees to accurately calculate their anticipated out-of-pocket costs, including premiums, copays, co-insurance and deductibles. With the growing trend of high deductible plans, we urge HHS to make clear which benefits are available to consumers without having to meet the plan deductible. Requiring the information to be available in a machine-readable format will also help enrollees, and we encourage HHS to explore alternative methods for providing plan information to people without internet access.

### **Guaranteed Availability**

Under the proposed rule, an insurer would not violate the federal guaranteed availability requirement if it attributes payments from a consumer or employer re-enrolling with the insurer to outstanding debt for coverage in the individual or group market during the previous 12 months. We understand HHS has concerns about individuals taking advantage of the current interpretation of guaranteed availability; however, we urge a reasonable payment plan and hardship exemption.

HHS requests comments on whether insurers should be allowed to adopt a policy of accepting partial payment and whether insurers that adopted a debt payment requirement should have to give notice regarding their policy. The Arthritis Foundation urges HHS to require insurers to provide reasonable notice regarding any policy changes, so as not to disrupt a stable patient's care.

### **Special Enrollment Periods**

HHS proposes many changes to the special enrollment periods. We are concerned that allowing only 30 days to provide enrollment verification documentation is not enough time, especially for enrollees who live in rural areas and have no or limited access to technology. We ask that HHS allow reasonable time to provide enrollment verification documentation. We are also concerned that any extra paperwork burdens or fragmentation in the verification process could discourage people from enrolling. The Arthritis Foundation believes HHS should pilot test the proposed changes to the special enrollment periods before fully implementing them. Further, people

should have access to personal support resources such as Navigators for special enrollment periods. A 2017 study found that nearly a third of California Exchange enrollees made suboptimal plan choices, missing out on financial assistance opportunities<sup>i</sup>. To improve the affordability of enrollees' health insurance and create overall health savings within the Exchanges, HHS should support the use of Navigators to steer enrollees away from making suboptimal plan choices.

Under the proposed rule, an enrollee would have to add a new dependent to their Qualified Health Plan (QHP), or, if that is not possible, to another QHP in the same metal level (or in an adjacent metal level, if no QHP in the same metal level is available). We encourage HHS to closely consider enrollee health status for plans and the costs for families. If a bronze plan level enrollee adds a new dependent that has complex care needs, a bronze level plan may not fit the needs of that dependent. We believe enrollees should have a choice of any plan level to adequately fit their complex care needs.

HHS proposes to significantly limit the use of the exceptional circumstances provision. The proposed rule states exceptional circumstances will have to be “truly exceptional” and verified by supporting documentation where practicable. We seek clarity on the definition of “truly exceptional” and request that HHS provide further guidance on when the more rigorous test applies before implementing such practices.

If an enrollee is denied coverage during a special enrollment period, we seek clarity on the appeals process. HHS should include a provision to streamline the appeals process. We believe a transparent, time limited, streamlined and simple appeals process is critical to ensuring enrollees know what options they have to appeal and are given the tools to act. We believe written disclosures of an adverse coverage decision or denial should be required, stating the specific reason for the adverse determination, the period of time permitted to make an appeal, the form of the appeal (e.g. written or web based electronic) and the location where the appeal must be submitted (e.g. street address or URL).

### **Continuous Coverage**

HHS proposes to change the individual mandate to a continuous coverage provision. We are concerned that patients could get “sicker” while waiting for coverage if a 90-day rule is implemented. As HHS works to finalize this provision, our main priority is that patients do not experience a lapse in coverage. With regard to the Medicare eligible population, we suggest HHS utilize resources such as Navigators, brokers and the state departments for the elderly to help patients transition into Medicare. We also encourage HHS to consider incentives for people who do keep continuous coverage.

## Actuarial Value

With the proposed changes to actuarial value (AV), HHS estimates it could lower premiums by 1 to 2 percent. Though we are encouraged to see HHS working to reduce premiums, we are concerned that overall cost-sharing could increase for patients. While insurers may offer lower premiums, we believe patient cost-sharing responsibility could increase in other areas to off-set the premium reductions. Further, if enrollees qualify for any premium tax credits, they may have to choose between paying more for premiums or for other forms of cost-sharing. We are concerned that patients could have difficulty making this decision without personalized support. High costs put patients' access to life changing treatments at risk. Recent studies show that the higher the out-of-pocket costs, the less likely patients are to take their medications on time, if at all<sup>ii</sup>. We also believe that implementing the proposed changes in 2019 would be too soon to make AV changes and construct adequate plan designs.

We believe there are currently inadequate patient protections against discrimination in the Marketplace. In particular, people with arthritis can experience a range of discriminatory practices, including high specialty tier co-insurance, inappropriate tiering of drugs and inappropriate use of utilization management techniques. A 2016 study found that insurers design their Exchange formularies to deter enrollment of unprofitable high cost individuals. When the researchers analyzed insurer marketing patterns, they found an Exchange consumer choosing a drug in the top 10% of unprofitable drugs (by the ratio measure) would face a restrictive tier 76% of the time, while a consumer with employer-sponsored insurance (ESI) would face a restrictive tier 45% of the time<sup>iii</sup>. The Arthritis Foundation is concerned because drugs like immunosuppressants and biologic response modifiers, potentially costing in excess of \$4,000 per month, are deemed unprofitable classes. The out-of-pocket costs associated with even a 20% coinsurance would routinely push such patients to their annual out-of-pocket maximum within the first few months of the plan year. We urge HHS to work with the states and other federal departments to issue clear guidance on discriminatory benefit design to provide needed protections to these enrollees.

Utilization management techniques are on the rise, from 27 percent in 2005 to 73 percent in 2013<sup>iv</sup>. According to a 2016 survey of Arthritis Foundation Advocates, 45% of respondents had to go through a step therapy protocol for their prescription drug, with 33% of those Advocates having to try three or more medications before getting the one initially prescribed by their provider<sup>v</sup>. Arthritis is a chronic condition, and therefore people who suffer from the disease have chronic health needs. When patients receive the right treatment at the right time, as determined by their physician, there are reduced complications, fewer follow up visits and potentially greater savings to the healthcare system<sup>vi</sup>.

## Network Adequacy

The Arthritis Foundation supports HHS efforts to align with the National Association of Insurance Commissioner's (NAIC) Model Act. We believe the Model Act moves the network adequacy accreditation process in the right direction, but we urge HHS to provide states with the resources needed to adequately ensure plans are in compliance with network adequacy standards. To our knowledge, no states have adopted the NAIC Model Act as of yet, so there is a continued need for state and federal oversight. Further, we caution against relying solely on issuer accreditation in the absence of state accreditation and believe issuer accreditation is not a substitute for federal oversight. We seek clarity on how accreditation agencies will resolve consumer grievances and how they will take action against an insurer with an inadequate network, other than to refuse accreditation.

Further, while we support many aspects of the Model Act, we believe more quantitative standards are necessary to measure network adequacy. Network adequacy is of huge importance to people with arthritis, as this is a population that requires regular, on-going access to both primary and specialty care. We support information such as wait times and whether a provider is accepting new patients being included as criteria to evaluate network breadth. As HHS determines the specific network adequacy criteria issuers will have to meet, the AF recommends that at a minimum:

- Plans must ensure access to care in a way that does not negatively impact an enrollee's health.
- Plans must ensure a sufficient number of geographically accessible health care providers for the number of enrollees in a given region.
- Plans must ensure a minimum level of access to care based on clinical appropriateness, the nature of the specialty, and the urgency of care.
- Plans must ensure a network that includes sufficient health care providers in each area of specialty practice to meet the needs of the enrollee population.
- An insurance plan that is unable to provide sufficient access to required provider's must ensure that an enrollee may obtain a covered benefit at no greater cost to the person than if the benefit were obtained from participating providers.
- Plans must ensure the ability to select specialty practice health care providers within a reasonable travel time and distance – taking into account the conditions for provider access in rural areas.
- Plans must ensure a sufficient range of services.
- Plans must not exclude any type of health care provider as a class.

## Essential Community Providers

HHS proposes that for 2018, it would require plans to include only 20 percent of Essential Community Providers (ECPs) within their network, rather than the 30 percent that is currently

required. HHS claims that this would “substantially lessen the regulatory burden on issuers while preserving adequate access to care provided by ECPs.” We have several concerns regarding this proposal. ECPs serve predominately low-income, medically underserved individuals. We are concerned that reducing the required percentage of ECPs from 30% to 20% is decreasing a standard of care many people depend on. ECPs provide important services specifically developed to address the health needs of low income individuals, including language services, patient support services, coordination of health and social services and availability of care in a low-income community<sup>vii</sup>. With a reduction in qualifying ECPs, we are concerned patients will experience increased travel times and disruption of care.

Again, thank you for the opportunity to comment on the HHS *Patient Protection and Affordable Care Act; Market Stabilization Proposed Rule CMS-9929-P*. Please contact Sandie Preiss, Arthritis Foundation National Vice President of Advocacy and Access, at 202-887-2910 or spreiss@arthritis.org with questions or for more information.

Sincerely,



Sandie Preiss  
Vice President, Advocacy and Access  
Arthritis Foundation

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<sup>i</sup> Fung, V. et al., (2017). *Health Affairs*. January, vol. 36 no. 1 21-31. doi: 10.1377/hlthaff.2016.0472

<sup>ii</sup> Pasma A, Schenk C, Timman R, van 't Spijker A, Appels C, et al. (2017) Does non-adherence to DMARDs influence hospital-related healthcare costs for early arthritis in the first year of treatment?. PLOS ONE 12(2): e0171070. doi: 10.1371/journal.pone.0171070

<sup>iii</sup> Geruso, Michael and Layton, Timothy J. and Prinz, Daniel, Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges (November 10, 2016). Available at SSRN: <https://ssrn.com/abstract=2867542> or <http://dx.doi.org/10.2139/ssrn.2867542>

<sup>iv</sup> Chung, A., MacEwan, J., & Goldman, D. (2016)

<sup>v</sup> Arthritis Foundation. (2016). [2016 Step Therapy Survey]. Unpublished raw data.

<sup>vi</sup> Farley, J. et al., “Retrospective assessment of Medicaid step-therapy prior authorization policy for atypical antipsychotic medications,” *Clinical Therapeutics*, 30: 1524-1539, 2008.

<sup>vii</sup> Rosenbaum, S., Essential Community Providers, Health Reform GPS, 2011 citing Institute of Medicine, America’s Health Care Safety Net: Intact but Endangered (Washington D.C. 2000); D. Hurwitz et al., Essential Community Provider Initiative, Enhancing Access, quality, and Cost Effectiveness of Health Care for MassHealth Members and Other Low Income Residents (Commonwealth Medicine, Boston, MA. 2004).