Regulatory Education and Action for Patients

Seeking Common Ground

February 21, 2013

Mr. Gary Cohen
Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: **CMS-2334-P- Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing.**

Dear Director Cohen:

The Regulatory Education and Action for Patients (REAP) Council would like to thank you for the opportunity to comment on the Proposed Rule entitled "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing " (the Proposed Rule), which was published in the *Federal Register* on January 22, 2013.[1]

REAP is an umbrella coalition comprised of patient advocacy groups whose goal is to strengthen current relationships and build new relationships with government agencies that have the responsibility for implementing provisions of the Patient Protection and Affordable Care Act (PPACA or the Act),[2] as amended, and to ensure that implementation of the Act's provisions is patient-centric. The unique experience and expertise of each REAP member organization allows REAP to provide the patient voice in a cross-disciplinary manner.

REAP's mission is to communicate issues to Federal and State regulatory bodies, Congress, health care insurers and others to regulate, develop, manage and/or impact health delivery, coverage, cost, and availability of services to the United States population. REAP will, through its member entities,

[1] 78 Fed. Reg. 4594 (Jan. 22, 2013).
[2] Pub. L. 111-148.

contribute information and perspectives regarding important health care decisions to a degree that has not been possible heretofore by health care advocacy groups in the regulatory arena.

Both REAP and its member organizations are deeply committed to the expansion of access to affordable health insurance for all Americans under PPACA. We are proponents of state and federally-facilitated health insurance Exchanges and we advocate for the development of various forms of health coverage, including the expansion of state Medicaid and Children's Health Insurance Programs (CHIP) programs, Basic Health Plans (BHPs) and the development of consumer-friendly Exchanges where Qualified Health Plans (QHPs) will be offered. We are encouraged by the emphasis in the proposed rule on coordination among various insurance affordability programs including state Medicaid programs, CHIP programs, BHPs and QHPs offered via the Exchanges in the Proposed Rule. In addition, we commend CMS for ensuring the availability of health coverage under Medicaid is transparent to beneficiaries and prospective beneficiaries.

We have centered our comments around two of our overarching REAP principles—individual access to health care and transparency in process—that we believe will help the Centers for Medicare & Medicaid Services (CMS) fine-tune the Proposed Rule to ensure that all insurance affordability programs, including state Medicaid programs, CHIP programs, BHPs and QHPs, offered via the Exchanges are patient-centric.

Proposals Related to Individual Access to Health Care

Coordination Among State Medicaid, CHIP Programs and the Exchanges

In the Proposed Rule, CMS focuses extensively on ensuring that the application, enrollment and appeals processes across various insurance affordability programs are streamlined. REAP members champion this approach, which should help make the eligibility process for the various programs less daunting for individuals. CMS begins the coordinated process by proposing to establish one streamlined application for enrollment in QHPs as well as state Medicaid and CHIP programs. We urge CMS to ensure the eligiblity and enrollment applications developed by the states are written in plain language and provided in a manner that affords meaningful access to persons with disabilities and with limited English proficiency. In addition, REAP members recommend that the streamlined application be available both electronically and in print. Furthermore, it is critical that individuals be able to complete the electronic application on their smartphone or mobile device, since many low-income individuals may not have consistent access to a home or personal computer.

In addition to proposing one streamlined eligibility and enrollment application, CMS has proposed requiring that the Exchanges and state Medicaid and CHIP programs issue one combined eligibility notice to an applicant who applies for the programs on the basis of Modified Adjusted Gross Income (MAGI). Per CMS, the combined eligibility notice should include information for all members of a given household who are eligible/ineligible for programs based on the same MAGI. We applaud CMS for the proposal to issue a combined eligibility notice, as this coordinated approach allows consumers to only apply once and receive one simple notice that addresses a broad spectrum of potential health insurance coverage and premium/cost-sharing assistance options for all members in a given household. We urge CMS to work diligently with the states to develop model combined eligibility notices that present information in understandable plain language and in a manner that is meaningful to persons with disabilities and with limited English proficiency.

Similarly, we applaud CMS' proposal to allow states to offer one coordinated appeals process related to potential eligibility for Medicaid, CHIP, BHPs, as well as premium tax credits and cost-sharing assistance related to QHPs sold through Exchanges. As with the original application process, streamlining the appeals process across Medicaid, CHIP and the Exchange options will make the process less burdensome for consumers. In addition, we applaud CMS for requiring state Medicaid agencies to hear appeals related to the denial of Medicaid coverage when individuals specifically request a hearing by the Medicaid agency. This approach allows states to opt for a single appeals process, which, we suspect, in most instances will be utilized by consumers for simplicity, while still affording individuals due process related to Medicaid denials specifically, which is particularly critical since the Medicaid program provides coverage for an especially needy and vulnerable patient population.

Proposed Cost-Sharing for Drugs

REAP members are concerned that CMS' proposal permitting state Medicaid programs to establish a 20% co-insurance on non-preferred drugs for Medicaid enrollees with incomes at or above 150% of the Federal Poverty Level (FPL) will negatively impact beneficiary access to needed drug therapies. We certainly understand the desire to encourage the use of cost-effective generic equivalents and lower-cost preferred brand-name drugs in certain therapeutic classes. However, such lower-cost therapies are not always medically indicated for certain patients; some patients may experience adverse side effects to any given medication; and, as with many biologics and specialty drugs, different patients may respond differently to various therapeutic alternatives. REAP members are concerned that beneficiaries will be financially penalized for using certain branded medications even when deemed medically necessary by their treating providers. A 20% co-insurance can be substantial depending on the cost of a given drug therapy and such a substantial cost-sharing obligation might result in patients simply not obtaining needed drug therapies, as well as lapses in medication adherence. We recommend that CMS reduce the proposed 20% co-insurance to a more reasonable level for the vulnerable Medicaid population and, at a minimum, adopt a maximum cost-sharing ceiling expressed in dollars such that a Medicaid patient's cost-sharing obligation for non-preferred drugs will not exceed a realistic dollar threshold.

The Proposed Rule requires that if a state Medicaid program adopts differential cost-sharing obligations for preferred and non-preferred drugs, it must have an exception process pursuant to which a non-preferred drug is covered as a preferred drug if a patient's prescribing physician determines that the preferred drug for treatment of the same condition would either be less effective for the patient or would have adverse effects on the patient. We applaud CMS for including such an exception process in the Proposed Rule. However, CMS has left it to the individual state Medicaid programs to determine the parameters governing such exception processes. We recommend that CMS define the required exception process to ensure that it is efficient for beneficiaries, such that beneficiaries receive coverage of needed drug therapies in a timely manner.

Proposed Cost-Sharing for Services Furnished in a Hospital Emergency Department

REAP members harbor concerns that CMS' proposal to allow state Medicaid programs, at their discretion, to charge Medicaid beneficiaries additional cost-sharing for non-emergency services provided in hospital emergency rooms will unintentionally inhibit beneficiary access to needed care. If state Medicaid programs require Medicaid beneficiaries with incomes at or above 150% of the FPL to be responsible for 100% of the cost of non-emergency care provided in emergency rooms, beneficiaries with true emergencies may be dissuaded from seeking care in an emergency room out of fear that their condition does not meet the definition of "emergency" and they will be financially liable for the visit. Furthermore, beneficiaries with non-urgent matters may put off care when primary care alternatives to hospital emergency rooms are not available to them during non-work hours. In order to remedy potential access issues linked to this proposal, we recommend that CMS define emergency and non-emergency indications in sufficient detail and in understandable terms to enable Medicaid beneficiaries to determine when to seek care in a hospital emergency room and when to seek care through other providers.

In addition, state Medicaid programs must ensure that alternative providers, such as primary care physicians, pediatricians and clinics, are available to beneficiaries at various times and at convenient locations. Many Medicaid beneficiaries are unable, due to work commitments and otherwise, to visit a health care practitioner during normal work hours. Therefore, it is imperative that state Medicaid programs ensure that health care resources for non-urgent matters outside of hospital emergency rooms are available at nights and on weekends. We also encourage CMS to reduce the proposed cost-sharing for non-emergency services provided to Medicaid beneficiaries in hospital emergency rooms down from 100% of the incurred charges to a more reasonable level for the vulnerable Medicaid population and, at a minimum, to adopt a maximum cost-sharing ceiling expressed in dollars such that a Medicaid patient's cost-sharing obligation for non-emergency services provided in a hospital emergency room will not exceed a certain dollar threshold.

In addition, REAP members are concerned that the safeguards CMS has proposed to ensure that Medicaid beneficiaries are aware they are about to receive non-emergency services in a hospital emergency department, and will be responsible for additional cost-sharing, are insufficient to fully inform such individuals of what this entails financially. We recommend that CMS require hospital emergency departments to inform such individuals, in writing, of their financial liability related to the provision of non-urgent care in the emergency room and obtain the individuals' signatures prior to providing such non-emergency care.

Medicaid Termination for Failure to Pay Premiums

We are concerned about CMS's proposal that would permit state Medicaid programs to terminate from the Medicaid program individuals who are charged premiums if their incomes are at or above 150% of the FPL and they have been delinquent in paying their premiums for 60 days. Given the vulnerability of the Medicaid population and the desire to ensure access to health care for such individuals, we believe state Medicaid programs should be required to reach out to the individuals to ascertain a reason for the payment delinquency and assess whether an exception is warranted prior to terminating beneficiaries from their state Medicaid programs. We suggest that CMS mandate that state Medicaid programs implement an outreach program prior to permitting termination for failure to pay premiums as well as an exception process pursuant to which beneficiaries can request a longer payment timeframe due to extenuated circumstances.

Accommodations for the Disabled and those with Limited English Proficiency

REAP members applaud CMS for requiring that state eligibility appeals processes for Medicaid, CHIP, BHPs and cost-sharing and premium tax credits related to QHPs sold via Exchanges provide, among other things, oral interpretation and written translation services for the disabled and those with limited ability to speak English. CMS is commended for requiring that eligibility notices be in plain and understandable language and made available with taglines in languages other than English.

QHP Eligibility Not Impacted by Temporary Absences

The Proposed Rule requires that state Medicaid programs and QHPs offered through Exchanges continue to cover an individual temporarily absent from a region so long as the individual plans to return to the area and the individual does not meet the residence requirements for another Exchange. We applaud CMS for recognizing that merely because an individual is out of a region for a period of time does not necessarily mean the individual has moved and is no longer eligible for health coverage in the region. An individual may need to leave a region due to work commitments or to care for an ailing relative, and such absences do not mean that the individual has abandoned his/her residence.

Transparency in Coverage under State Medicaid Plans

REAP members are excited to see that, under the Proposed Rule, state Medicaid programs would be required to publish on their websites schedules outlining the parameters of Medicaid coverage, including current premiums, cost-sharing requirements, hospitals charging cost-sharing for non-emergency use of the emergency department and a list of preferred drugs. We encourage CMS to ensure that information published on state Medicaid websites on Medicaid coverage, limitations and parameters be in a simple format, easy to navigate and unencumbered with graphics that will slow down Internet operations so beneficiaries and potential beneficiaries will be able to view such information on smartphones or other mobile devices, which are often utilized by lower-income individuals as personal computers.

REAP commends CMS for mandating that state Medicaid programs publish for notice and comment State Plan Amendments aimed at substantially modifying existing premium or cost-sharing requirements under their state Medicaid programs prior to filing such State Plan Amendments with CMS. However, CMS did not propose a definition for "substantial," which triggers the "notice and comment" requirement. As "substantial" can mean different things to different people and in different states, we encourage CMS to adopt a uniform definition of "substantial," considering the low-income population covered by state Medicaid programs.

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Again, we appreciate the opportunity to share our perspective on the Proposed Rule with you. REAP stands ready to answer questions and provide any additional information about the patient groups for whom we advocate.

Sincerely,

Alpha 1 Association
Alpha 1 Foundation
American Kidney Fund
Arthritis Foundation
Bladder Cancer Advocacy Network
C-Change
Cancer Support Community
Children's Cause for Cancer Advocacy
COPD Foundation
Cutaneous Lymphoma Foundation
Fight Colorectal Cancer
Friends of Cancer Research
HealthHIV
International Myeloma Foundation
Leukemia Lymphoma Society
The LIVE**STRONG** Foundation
National Alliance on Mental Illness
National Patient Advocate Foundation
National Psoriasis Foundation
Ovarian Cancer National Alliance
Parkinson's Action Network
Prevent Cancer Foundation
Sisters Network
Susan G. Komen for the Cure
Us TOO International Prostate Cancer Education and Support Network
Zero - The Project to End Prostate Cancer