American Heart Association | American Stroke Association
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December 22, 2014

The Honorable John O'Brien
Director
Healthcare & Insurance Division
U.S. Office of Personnel Management
1900 E Street NW
Washington, DC 20415

RE: RIN 3206-AN12 (Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges)

Dear Director O'Brien:

On behalf of the American Heart Association (AHA), including its American Stroke Association (ASA) division, and more than 22 million volunteers and supporters, we appreciate this opportunity to submit comments on the Office of Personnel Management's (OPM) proposed rule, "Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges."

The AHA/ASA has long advocated for all Americans to have access to affordable, quality health insurance coverage. Access to affordable, quality health care is critical to helping the Association achieve its ambitious goal to prevent as many heart attacks and strokes as possible, as well as reduce the risk factors for these conditions. The Multi-State Plan (MSP) Program provides consumers with additional affordable health insurance options through the health insurance marketplaces.

Although this proposed rule covers a number of important topics, we have focused our specific comments below on a number of issues that we believe are particularly critical to people with heart disease or stroke.

Benefits (§800.105)

OPM is proposing to offer MSP issuers more flexibility in the selection of the essential health benefits (EHB) benchmark plan used to determine their package of benefits, specifically by allowing the issuer to offer more MSP options in each state using different benchmarks for each product. We have serious concerns about this approach. As we and other patient and consumer groups have commented previously, having so many different options available is overly complicated and unjustified and would

lead to unnecessary confusion for consumers. In any given state, rather than having all plans based on the same benchmark, a consumer could potentially need to distinguish between plans based on four different benchmarks (as each MSP issuer in a state could offer products based on the state-selected benchmark and each of the three benchmark options selected by OPM). Given that OPM has previously indicated that its three benchmark options are substantially similar and in most states issuers also have the option to make actuarially equivalent substitutions, we don't believe this approach provides much, if any, added value to consumers. Instead it could open the door for gaming by issuers and would hurt consumers' ability to make "apples to apples" comparisons of plans. Issuers should be encouraged to compete based on other plan features, such as premium and cost-sharing.

Accordingly, we encourage OPM to reconsider offering issuers more flexibility and instead require MSP issuers to follow the state-selected benchmark in each state in which they operate. Alternatively, OPM should consider limiting the number of OPM-selected benchmark plans to one rather than three.

With respect to habilitative services, we support OPM's proposal to adopt a uniform federal definition of habilitative services, with the following caveats. First, we believe that such a definition should serve as a federal floor for defining habilitative services. While we agree that states should have the flexibility to define habilitative services in a manner at least as strong as the federal definition, states with weaker definitions than the uniform federal definition should be required to either strengthen their definition or use the federal definition. Such a policy is consistent with the general preemption standard in the ACA, in which states are allowed to be more protective of consumers but cannot impose weaker protections. Therefore, we urge OPM to amend its proposed rules to make it clear that the MSP issuer should follow whichever definition is stronger.

Second, we support defining habilitative services based on the definition from the Glossary of Health Coverage and Medical Terms that was developed by the National Association of Insurance Commissioners (NAIC)[1], as we have previously recommended. However, we note that the definition included in the Department of Health and Human Services' (HHS) proposed rule is not the full definition adopted by the NAIC. We also recommend the addition of devices to the uniform definition, since devices are specifically included in the statute. In our comments to HHS on its proposed Notice of Benefit and Payment Parameters for 2016, we have strongly encouraged HHS to adopt the NAIC's full definition with the inclusion of devices. If HHS does not adopt a uniform definition or adopts a weaker uniform definition, we urge OPM to nevertheless adopt the NAIC's definition as stipulated above.

Third, we recommend that OPM make it clear that any limits imposed on habilitative services must be separate from and no less favorable than any such limits on rehabilitative services, as HHS is proposing in its rule. We note, however, that in many cases, even with separate limits, the caps on rehabilitative and habilitative services are

[1] The NAIC defined "Habilitation Services" as "Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't 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."

inadequate and in our view violate requirements that EHB benefit design not be discriminatory. We will discuss this in greater detail later in our comments.

We also applaud OPM's intention stated in the preamble to review an MSP issuer's package of benefits for discriminatory benefit designs. The American Heart Association has seen a number of different plan designs that we believe discriminate against patients with chronic or disabling conditions and/or serve to discourage enrollment of individuals with chronic health needs. We have not conducted an exhaustive review of MSP options to determine to what extent the following examples may be occurring within the MSP Program. However, we are sharing these examples with OPM so that you might consider them as part of your review for MSP options in 2016.

- Some plans are imposing arbitrary and unreasonable quantity limits on outpatient therapy that disproportionately impact patients, such as stroke survivors, who need multiple types of rehabilitative services to recover. For example, an MSP option in Georgia is imposing a 20 visit annual limit for PT and OT combined and a 20 visit limit for SLP. For a stroke patient who is likely to need all three types of outpatient therapy, this limit translates into only a few weeks of outpatient rehabilitation. It is highly unlikely that most stroke patients can learn how to walk or talk again with such limited coverage and their recovery may be slowed or incomplete (with attendant costs to the healthcare system).

- Likewise, some plans are also imposing limits on cardiac rehabilitation that are not sufficient based on the medical evidence. Under evidence-based guidelines, a full course of cardiac rehabilitation (CR) is generally 36 sessions over 12 weeks. Research has shown that participating in CR can reduce cardiac mortality by as much as 31 percent and it has also proven beneficial in preventing a second heart attack. Unfortunately, however, contrary to evidence-based medical guidelines, we have seen plans that are imposing inadequate and arbitrary visit limits.

- Some plans are imposing very high co-pays or co-insurance on specific services more likely to be used by patients with disabling medical conditions, effectively discouraging them from enrolling in those plans or accessing those services. For instance, we have seen plans that charge 50 percent coinsurance per in-network outpatient therapy visit. For a patient who has a heart attack or bypass surgery and who needs cardiac rehabilitation to help prevent another cardiac event, his or her out-of-pocket costs for cardiac rehab would likely be $2,000 or more for the amount of cardiac rehab recommended by evidence-based medical guidelines. Many stroke patients would also have high out-of-pocket costs for the therapy they need to learn to walk, talk, and function again.

- Some plans are charging a high co-insurance for prescription medications. Co-insurance as high as 40 or 50 percent put access to lifesaving medications out of reach for many people, particularly if they don't have other options for medications available on a lower formulary tier. We've also seen a number of 2015 plans that appear to violate the provision of the ACA requiring that plans

charge consumers in-network cost-sharing for out-of-network emergency services.

It is critically important that OPM, as well as HHS and state regulators, more aggressively enforce the ACA non-discrimination provisions. We have recommended to HHS that it issue regulations that further define practices that constitute discrimination. For example, regulation should make it clear that limits must be grounded in medical evidence and regulators should disapprove plans that include arbitrary limits. OPM and other regulators could also require plans that impose limits to have an "exceptions process" that enables enrollees to access medically-necessary care that exceeds the limits, as exists in Medicare for beneficiaries who need more outpatient therapy than its caps allow. When reviewing plan cost-sharing requirements, OPM and other regulators should evaluate whether high cost-sharing rates for specific categories of services, such as rehabilitation and habilitation, are likely to discourage enrollment of those with disabilities or chronic health needs and are therefore discriminatory.

Network Adequacy (§800.109)

We support OPM's proposal to require MSP issuers to comply with any additional standards related to provider directories that are set by HHS for qualified health plans (QHPs). We strongly support the new provider directory requirements being proposed by HHS for QHPs, such as requiring issuers' provider directories to be "up-to-date, accurate, and complete" and requiring directories to be available without consumers having to create or access accounts on issuer websites or having to enter policy numbers. Therefore, we are pleased that OPM is planning to apply these requirements to MSP issuers, but we encourage OPM to broaden this requirement to other network adequacy standards that may be set by HHS for QHPs moving forward.

In order for health care to be truly available and affordable to Americans, consumers need three things: 1) affordable health insurance, 2) coverage for the essential benefits they might need, and 3) timely access to health care providers that can provide the covered care. The two top and, at times competing, priorities for consumers when choosing health care coverage are cost and the inclusion of the providers they need in their health plan's network. These priorities are at the crux of the issues related to network adequacy, and consumers recognize the need to balance these priorities. The bottom line is that health insurance coverage is meaningless if consumers cannot get the covered benefits promised to them. Therefore, the Association supports stronger network adequacy standards for QHPs as well as other private health plans that use networks. The Association, through our Consumer Representative to the National Association of Insurance Commissioners (NAIC), has been very actively involved in the NAIC's efforts to update its network adequacy model law. We hope and expect that NAIC will complete its revisions early next year and that HHS will incorporate stronger network adequacy requirements for the 2017 plan year. In the event this occurs, MSP issuers should also be required to comply with these standards.

On a related note, we encourage OPM to pay particularly close attention to the following issue when assessing MSP options for network adequacy: Are plans that contract with hospitals to be in-network also including sufficient in-network physicians, such as emergency department doctors, anesthesiologists, radiologists, and hospitalists, at those

in-network hospitals? Analysis of data from Texas PPO plans by the Center for Public Policy Priorities found that for two of the largest insurers in the state, 48 percent and 56 percent of their in-network hospitals, respectively, had not a single in-network Emergency Department physician. One plan in particular also reported that 38 percent of their in-network hospitals had no in-network anesthesiologists and 31 percent had no in-network radiologists. This leaves consumers vulnerable to balance billing---producing economic hardships and perpetuating disparities in healthcare in our country.

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Thank you again for the opportunity to share our comments on these issues related to provision of essential health benefits and network adequacy through MSP options. If you have any questions, please feel free to contact Stephanie Mohl, Senior Government Relations Advisor, at Stephanie.Mohl@heart.org or 202-785-7909.

Sincerely,

Elliott M. Antman, MD, FAHA
President