November 4, 2015

The Honorable Sylvia Matthews Burwell
Secretary of Health and Human Services
U.S. Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20201

RE: Nondiscrimination in Health Programs and Activities Proposed Rule (RIN 0945—AA02)

Dear Secretary Burwell:

On behalf of the American Heart Association/American Stroke Association, thank you for the opportunity to submit comments in response to the Notice of Proposed Rule Making for Section 1557 of the Affordable Care Act (ACA). We commend the Department of Health and Human Services (HHS) and the Office of Civil Rights for issuing proposed regulations that take critical steps toward realizing the promise of Section 1557 in addressing discrimination in health care.

Heart disease and stroke are the No. 1 and No. 5 killers of Americans, respectively and exact an enormous health and economic toll on patients, their families, and our nation as a whole. The Association has long recognized access to affordable, adequate health insurance coverage is crucial to meeting our 2020 goals of improving the cardiovascular health of all Americans by 20 percent while reducing deaths from cardiovascular diseases and stroke by 20 percent.

The ACA took historic steps forward by explicitly prohibiting the most blatant forms of discrimination in health insurance. The bans on denying coverage and charging higher premiums for individuals simply because they had a medical condition and the ban on charging women higher premiums for the same coverage as men are going a long way towards making health insurance accessible and affordable to uninsured consumers, including millions of heart disease and stroke patients.

Section 1557 of the law complements these critical patient protections by prohibiting discrimination in all federally funded, supported and conducted health programs and activities. We strongly support the rule's prohibition on discrimination on the basis of race, color, national origin (including immigration status and language), sex (including sex stereotyping and gender identity), disability, and age. This proposed rule will help to ensure that *all* Americans are able to get the coverage and care they need and to address health care disparities.

Although the proposed rule will go a long way towards ending discrimination in health care, we urge HHS to further strengthen the rule as set out below and move expeditiously in finalizing and implementing the regulations, delivering on Section 1557's new protections.

Nondiscrimination in Health-Related Insurance — Sec. 92.207

We strongly support applying nondiscrimination requirements to benefit design and marketing practices. Now that insurers are prohibited from "cherry picking" the healthiest patients by denying, cancelling, or refusing to renew policies for people with pre-existing medical conditions, we are concerned that some health plans may be turning to more insidious ways of discouraging those with chronic medical needs from enrolling in their coverage. We recommend that HHS make the following changes to strengthen the final rule:

- Explicitly define discrimination to include benefit designs that *discourage enrollment by* individuals based on age or disability.
- Define "benefit design" to include, at a minimum, cost-sharing, formulary design/tiering, provider networks, and limits on coverage of certain services by age or condition.
- Require issuers to base any limitations and exclusions in coverage on clinical guidelines and medical evidence.
- Require plans that impose limits to have an "exceptions process" that enables enrollees to access medically-necessary care that exceeds the limits, such as exists in Medicare for beneficiaries who need more outpatient therapy than its caps allow.

The American Heart Association has seen a number of different plan designs that we believe discriminate against patients with disabling conditions and/or serve to discourage enrollment of individuals with chronic health needs. In reviewing qualified health plans (QHPs) sold through the health insurance exchanges for 2015, we have found numerous examples of potentially discriminatory benefit design, such as:

- Imposing arbitrary and unreasonable quantity limits on outpatient therapy that disproportionately impact disabled patients, such as stroke survivors, who need multiple types of rehabilitative services to restore or maintain function. In the Association's analysis of more than 300 silver QHPs sold in all 50 states and the District of Columbia in 2015, 16 percent of plans had combined limits of 30 or fewer visits annually for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services and another 16 percent of plans had individual (per therapy type) limits of 20 or fewer visits. For example, plans in Idaho limit coverage for PT, OT, and SLP services to 20 total visits annually. Similarly, plans in Georgia and Mississippi are imposing a 20 visit annual limit for PT and OT combined and a 20 visit limit for SLP. For a disabled stroke patient who is likely to need all three types of outpatient therapy, this limit translates into only about 2 weeks of outpatient rehabilitation. It is unlikely that most stroke patients can learn how to walk or talk again with such limited coverage.

- Likewise, some plans are also imposing limits on cardiac rehabilitation that are not sufficient based on clinical guidelines. Under the American College of Cardiology Foundation/American Heart Association (ACC/AHA) 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. In our review and analysis of more than 300 silver QHPs being sold for 2015, we found that 21 percent of the plans that specifically mentioned CR coverage imposed quantity limits of 35 or fewer sessions – meaning coverage does not meet the medical guidelines for CR. For example 2 of the 3 silver plans sampled in Nebraska cover only 18 sessions of CR per cardiac event – half of the amount recommended by the ACC/AHA guidelines. One of the 15 plans sampled in Wisconsin limited CR coverage to only 20 visits. Two of the 15 plans sampled in Texas had a combined quantity limit of 35 visits for CR along with all other types of therapy services.
- 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, a silver plan in Tennessee charges a 50 percent coinsurance per *in-network* outpatient therapy visit.
- 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. Formularies that place all medicines for a specific condition on the highest cost-sharing tier is one example of a potentially discriminatory plan design. While formulary tiering can be an appropriate tool to encourage patients to use lower cost medicines, some plans are now reportedly placing all medications for certain conditions on the highest tier and leaving patients with no lower cost alternatives.
- Some plans are designing their provider networks in a potentially discriminatory manner, such that patients with disabling conditions are unfairly and adversely impacted or are discouraged from choosing that carrier's health plan. Research recently published in the *Journal of the American Medical Association* found that 13 percent of the plans sampled that were sold through federally-facilitated exchanges completely lacked an in-network specialist within a 100-mile radius for at least one specialty. While rheumatologists, psychiatrists, and endocrinologists were most likely to be excluded from plan networks, the researchers found examples of plans where not a single cardiologist, neurologist or oncologist was available in-network within 100 miles.[1] Likewise, Avalere Health found in a study commissioned by the Association that, while inclusion of Comprehensive Stroke Centers (CSC) in networks varied widely across the 10 regions studied, 23

[1] Dorner SC, Jacobs DB, and Sommers BD. Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act. *JAMA*. 2015; 314:1749-1750.

percent of QHPs did not include a single CSC in their network.[2] Other plans may be designing tiered networks such that specialty care is only available in the highest cost-sharing tier, with significant patient cost-sharing.

In addition to making the changes that we recommend above to further define what constitutes discrimination in health insurance, it is critically important that HHS and other regulators more thoroughly enforce the ACA non-discrimination provisions. For example, HHS and state regulators should disapprove plans that include arbitrary limits, excessive cost-sharing, or inadequate provider networks rather than relying on consumers to file a complaint with the Office of Civil Rights or a private right of action.

Meaningful Access for Individuals with Limited English Proficiency — Sec. 92.201

We strongly support the rule's specific requirements to ensure meaningful access for individuals with limited English proficiency. In particular, we support the definition of qualified interpreter, and we suggest including a definition of a qualified translator. Further, we strongly support including specific thresholds for translating written documents to ensure minimum standards exist that would directly aid evaluating compliance and enforcement. We also support requirements regarding taglines but recommend that covered entities include taglines in the top 15 languages in their state or service area rather than the top 15 languages nationally, as proposed. In many states, the top 15 languages nationally will not be useful for informing local limited English proficient communities.

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Thank you for this opportunity to submit recommendations on improving the regulations implementing Section 1557. We look forward to continuing to work with the Department to ensure that the ACA fully meets the needs of patients with or at risk for heart disease and stroke.

Sincerely,

Mark A. Creager, MD, FAHA
President

[2] Avalere Health, "Access to Comprehensive Stroke Centers & Specialty Physicians in Exchange Plans," September 26, 2014, available at: http://www.heart.org/idc/groups/public/@wcm/@adv/documents/downloadable/ucm_468318.pdf.