National
Family Planning
& Reproductive Health Association

February 19, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-2334-P
PO Box 8016
Baltimore, MD 21244-8016

Re: "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" (CMS-2334-P)

Dear Acting Administrator Tavenner:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to respond to the proposed rule issued by the Centers for Medicare & Medicaid Services (CMS) in the January 22, 2013, Federal Register, implementing certain provisions of the Affordable Care Act (ACA).[1]

NFPRHA is a national membership organization representing the nation's family planning providers – nurse practitioners, nurses, administrators and other key health care professionals. NFPRHA's members operate or fund a network of nearly 5,000 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 49 states and the District of Columbia.

NFPRHA supports CMS' efforts to streamline and improve eligibility and enrollment regulations and to remove barriers to coverage in the proposed rule. NFPRHA offers the following comments in support of key provisions and recommendations to address specific concerns and strengthen the proposed rule.

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Medicaid Eligibility Expansion

NFPRHA supports CMS' efforts to streamline eligibility and enrollment, which will reduce barriers to coverage. NFPRHA further supports CMS' efforts to update regulations and modernize administrative procedures in accordance with the changes in Medicaid eligibility created under the ACA and to promote

[1] Portions of these comments were adapted with the permission of the National Women's Law Center and the National Health Law Program (NHeLP).

coordination across programs. However, NFPRHA is concerned that certain provisions of the proposed rule could have a negative impact on coverage and services for low-income populations, and therefore offers the following comments to modify and strengthen the proposed rule.

I. §435.214 – Implementing §2303 of the ACA Improves Family Planning Access

NFPRHA thanks CMS for this regulation codifying §2303 of the ACA, the state plan option to expand Medicaid coverage of family planning services and supplies. In particular, NFPRHA supports the inclusion of the income eligibility standards for pregnant women under § 1115 demonstration waivers in determining the states' highest income standards for the purposes of setting income eligibility for family planning state plan amendments. NFPRHA also supports the amendment to § 457.310(b)(2)(i) indicating that eligibility for limited coverage of family planning under § 435.214 does not preclude an individual from being eligible for CHIP and that an individual can be eligible for both.

II. §435.4 – Excluding Deferred Action for Childhood Arrival Individuals Restricts Access to Vital Sexual and Reproductive Health Services for Immigrant Women

NFPRHA opposes the prohibition of health care coverage eligibility for individuals living and working in the US under the Deferred Action for Childhood Arrivals (DACA) policy. The specific exclusion of DACA individuals is discriminatory and will result in reduced access to family planning and other vital preventive health services for young immigrant women and men.

III. §435.1103 – Limiting Pregnant Women to One Presumptive Eligibility Period Per Pregnancy Is Unnecessarily Restrictive

The proposed rule specifies that presumptive eligibility for pregnant women is limited to one presumptive eligibility period per pregnancy and covered services are limited to ambulatory prenatal care. Access to comprehensive health coverage is vital for a healthy pregnancy, and these rules should ensure that pregnant women have every opportunity necessary to access the services they need. One presumptive eligibility period per pregnancy is unnecessarily restrictive. If a woman loses her job or her income changes during her pregnancy, she should be eligible for another presumptive eligibility period.

IV. Efforts to Streamline Citizenship Documentation Requirements Will Improve Access to Coverage for Low-income Populations

The proposed rule undertakes a number of important steps toward streamlining citizenship documentation requirements for individuals seeking coverage under the ACA. NFPRHA supports efforts to ease the citizenship documentation burden on individuals, as citizenship documentation requirements have proven to be a significant barrier to health care access.

Although the current citizenship documentation requirements were designed "to reduce Medicaid costs and prevent coverage of individuals who were in the country illegally," (proposed rule, p. 4618) these requirements have not achieved their intended purpose. In fact, as CMS cites in the proposed rule, a report by the Government Accountability Office (GAO) finds that "very few undocumented individuals apply for Medicaid or falsely claim [US] citizenship." (Proposed rule, p.

4618). As CMS goes on to say, the GAO report and other reports have documented that the citizenship documentation requirements have not only resulted in increased administrative costs, but also in "large numbers of eligible citizens, especially children, being inappropriately denied coverage, or their enrollment in Medicaid delayed." (Proposed rule, p. 4618).

NFPRHA is pleased by CMS' recognition that the current citizenship documentation requirements represent a barrier to coverage, and supports provisions of the proposed rule that seek to ease, improve, or streamline these requirements as a means to reduce barriers, such as:

- §435.956(a)(3): verification of citizenship is a one-time activity that should be recorded in the individual's file, and the agency may not re-verify citizenship, but must only check its records to confirm that the individual's citizenship has already been verified.
- §435.1008: requirement that states are entitled to receive federal financial participation (FFP) for benefits provided to individuals during the reasonable opportunity period - the period of time provided for individuals declaring US citizenship to provide verification - regardless of whether such eligibility is ultimately approved for such period.
- §435.407(f): removal of the requirement that individuals must provide an original copy of documents, and addition of the requirement that states accept copies of documents.

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Essential Health Benefits in Alternative Benefit Plans

NFPRHA supports the inclusion of the ACA's essential health benefits (EHB) requirements in Alternative Benefit Plans (ABPs), which include Medicaid benchmark and benchmark-lookalike plans, but cautions against providing states with too much flexibility so as to undermine continuity of health care services.

I. §440.345 - Codification of §2303(c) of the ACA Will Ensure Access to Essential Family Planning Services and Supplies Regardless of Medicaid Plan Type

§440.345 codifies §2303(c) of the ACA requiring that ABP coverage provided to individuals of child-bearing age include family planning services and supplies. NFPRHA thanks CMS for codifying this important provision, which helps to ensure that Medicaid beneficiaries can access essential family planning services and supplies regardless of the type of Medicaid plan in which they are enrolled.

II. §440.347 – EHB Requirements Should Be Strengthened to Better Meet the Needs of Vulnerable Populations

NFPRHA supports CMS' intent regarding the statutory requirement to make ABP coverage include, at a minimum, the EHB described in §440.347 of the proposed rule. However, NFPRHA recommends that HHS modify the regulation in two fundamental ways to better implement the EHB requirement and meet the needs of vulnerable Medicaid populations.

First, NFPRHA recommends that CMS require that ABP plans provide appropriate coverage to meet the needs of the population in all ten statutory EHB categories, as per the general requirement for ABPs in § 440.330. NFPRHA believes that the failure to specify minimum

standards in each of the ten categories is a flaw in the exchange EHB standard, and that this shortcoming has even graver consequences for the vulnerable enrollees in Medicaid. CMS should ensure that the EHB requirement is a strong floor for ABPs, and provide states with ample flexibility to add to that floor.

Second, NFPRHA is concerned that the flexibility CMS provides to states in the selection of EHB plans for each ABP could create too many standards of care. Administrative simplicity, oversight, and consumer understanding are all better served if the state has one EHB standard applicable for its qualified health plans (QHPs) and ABPs. NFPRHA therefore recommends that CMS require states to use a single EHB standard for its QHPs and ABPs. NFPRHA further recommends that CMS ensure that both QHPs and ABPs have adequate, overlapping provider networks so those individuals that traditionally seek care in the safety-net still have seamless access to their preferred providers regardless of payer source.

III. §440.130(c) – New Definition of Preventive Services Recognizes Diversity in Practitioner Types Providing Preventive Services

NFPRHA supports this change in the definition of preventive services, clarifying that preventive services includes those "recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under state law." This change recognizes the breadth of providers responsible for providing preventive health services in the safety net and the realities of the diverse health care workforce needed for the ACA to fully succeed.

IV. Too Much Flexibility in Utilization Control Measures Could Undermine Access to Essential Family Planning Services and Supplies

In Section 2(B)(1) of the preamble of the proposed rule, CMS states, "Consistent with the current law, states have the flexibility within those statutory and regulatory constructs to adopt prior authorization and other utilization control measures, as well as policies that promote the use of generic drugs." NFPRHA is concerned that this interpretation could provide too much flexibility for states in the use of utilization control measures, creating a barrier to necessary family planning supplies for Medicaid enrollees. Women need access to the full range of contraceptive methods in order to utilize the method most effective for them. Neither states nor plan issuers should be given the latitude to decide which preventive health benefits, including specific family planning services or supplies, are most effective for the plan enrollees. NFPRHA urges the Department of Health and Human Services (HHS) to issue sub-regulatory guidance that prohibits barriers to the full range of FDA-approved contraceptive methods guaranteed under the ACA.

V. Title XIX Cost-sharing Protections Should be Modified to Clarify that Preventive Services are Exempt from Cost-sharing

While the proposed rule appropriately requires that ABPs cover the full range of preventive services (e.g., "A" or "B" services recommended by the USPSTF; ACIP-recommended vaccines; preventive care and screenings delineated in HRSA's Bright Futures recommendations; and women's preventive services recommended by the Institute of Medicine), the preamble of the

proposed rule states that "Title XIX premium and cost-sharing provisions apply to preventive services." (Proposed rule, p. 4631). These critical services, which are part of EHB, must be offered to individuals eligible for Medicaid through the ACA's eligibility expansion without cost-sharing. To do otherwise would be inconsistent with statutory language and with other ACA-related rules promulgated by CMS and HHS. In contrast to this language in the preamble, regulatory language should clearly state that ABPs are required to cover these services without cost-sharing.

The statutory language of the ACA envisions that access to preventive services should not be limited by cost-sharing barriers. Section 1302 of the ACA, which establishes EHB, requires that deductibles cannot be applied to "preventive services described in §2713 of the Public Health Service Act." Further, §2713 of the Public Health Service Act (PHSA), as amended by the ACA, requires plans to cover these preventive services while prohibiting plans from imposing any cost-sharing requirements on these services. The statute also directs that individuals eligible for the Medicaid expansion must receive benchmark or benchmark-equivalent coverage described in § 1937(b)(1) and § 1937(b)(2) of the Social Security Act (SSA). These benchmarks – the Blue Cross/Blue Shield standard option plan for federal employees, a plan offered to state employees, and the largest commercial Health Maintenance Organization in the state – will all offer preventive services without cost-sharing.

In addition, the proposed regulatory language at § 440.347 already specifies that ABPs available to the Medicaid expansion population must cover EHB "consistent with the requirements set forth in 45 CFR Part 156." These requirements are laid out in proposed language on the provision of EHB, in §156.115 of HHS's recent *Notice of Proposed Rule Making on Standards Related to EHB, Actuarial Value and Accreditation*, which requires plans to include preventive health services described in § 147.130. The preamble to this proposed rule notes that EHB includes preventive services described in §2713 of the PHSA and that these services must be offered without cost sharing. The definition of preventive services in §147.130, in turn, has already been codified in the final rule on preventive services which delineates these services and requires that they be covered without cost-sharing.

NFPRHA therefore urges CMS to eliminate the conflict between the preamble of the proposed rule and the logic of the proposed rule's regulatory language, which requires coverage of EHB "consistent with" the proposed EHB rule. NFPRHA recommends that CMS eliminate the conflict by amending the proposed rule to clearly state that ABPs cannot impose cost sharing for preventive services on individuals enrolled in these plans.

While NFPRHA urges CMS to take action to ensure that ABPs do not impose cost sharing on the preventive services, NFPRHA commends CMS for recognizing the importance of family planning services and pregnancy-related services by prohibiting cost sharing and premiums for these services.

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Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges

NFPRHA supports CMS' efforts to streamline and clarify eligibility appeals and other provisions related to eligibility and enrollement. NFPRHA has two primary concerns, related to application counselors and assistors.

I. *§155.225 and §435.908 – Consumer Protections for Consumers Helped by Certified Application Counselors Should be Strengthened*

NFPRHA commends HHS for recognizing the importance that community based safety-net health centers play in enrolling eligible consumers into health insurance programs. The creation of a certified application counselor program at §155.225 building upon the expertise of safety-net providers will increase access to health insurance in the exchanges. Additionaly, giving states the option to certify application assistors working in state agencies at 435.908 will ensure that assistors already helping with Medicaid and CHIP enrollment can also assist with enrollment into exchange plans, creating a more seamless process for consumers. While NFPRHA applauds the creation of both these programs, consumer protections must be strengthened.

Currently the rule only requires that a certified counselor "agrees to act in the best interest of the applicant assisted. " The preamble makes clear that CMS believes that assistance being provided to individuals seeking to enroll in health insurance coverage through the exchange should be provided by individuals who are properly trained. Further, CMS suggests that certified application counselors have the same core functions as navigators. Navigators are held to a higher standard and are required to "provide information and services in a fair, accurate, and impartial manner." (45 CFR §155.210). Application counselors will be integral to ensuring individuals get access to the insurance coverage and NFPRHA proposes that application counselors be held to the same standard as navigators.

Additionally, the process of applying for health insurance may require that consumers accessing application assistance services through certified application counselors and assistors share sensitive information. CMS should require that certified application assistors and counselors disclose any additional information taken than what is required for the single streamlined application, and require that the certified counselor or assistor not make disclosure of this information a requirement to receive assistance.

The rule makes clear that certified application counselors and assistors cannot take money in return for helping to fill out the application. NFPRHA asks that this requirement makes it clear that in addition to not being able to "impose any fee on applicants for application assistance," that certified application counselors and assistors are not able to impose other requirements on the receipt of application assistance, for example, requiring that those requesting assistance undergo certain health care services or fill out other unrelated paperwork.

Finally, the rule should further require that certified application counselors and assitors be required to give information and advice that is medically and scientifically accurate and unbiased.

II. *§155.225 – Providing Application Services May be an Additional Burden on Health Centers to Perform Time-Consuming Work without Compensation*

Community based organizations like safety-net health centers are already struggling to meet the demand of outreach and enrollment into insurance programs, because these activities are rarely supported by outside funding or reimburseable. Many health centers already operate on a very tight margin, and adding an additional unfunded role would only further stretch slim resources. As stated in the preamble, these activities are necessary to the success of the exchanges. CMS should make resources available to safety-net providers, such as family planning providers, to respond to consumer information needs.

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Medicaid Premiums and Cost Sharing

Family planning has long been exempt from cost-sharing requirements in Medicaid, which continues to be good public policy. There is ample evidence that cost sharing can be a significant barrier to access to health care for low-income populations. Therefore, NFPRHA is concerned that the provisions in the proposed rule that would increase cost sharing – especially for low-income populations and regardless of however "nominal" they may appear – could negatively impact the ability of affected populations to access care. NFPRHA is particularly concerned with the cost-sharing provisions found in §447.52 and §447.53.

I. *§447.52 – The Cost-sharing Maximum for Patients Below 100% of FPL Should Not be Raised*

The proposed regulations for outpatient services replace the current tiered copayments with a single copayment based on the individual's income. HHS proposes to set the copayment for the below poverty population at $4.00—ten cents above the current FY 2013 maximum copayment amount. NFPRHA is opposed to this change, because even such a "nominal" increase could prevent millions of individuals from obtaining needed health care.

II. *§447.53 – Differential Cost-sharing is a Barrier to Accessing Necessary Drugs*

This section allows states to establish cost sharing for preferred and non-preferred drugs. Individuals with incomes at or below 150% FPL could be charged up to $4 copays for "preferred" drugs and $8 copays for "non-preferred" drugs. NFPRHA opposes this provision for several reasons.

Although family planning supplies have long been exempt from cost sharing in Medicaid, as noted earlier in these comments, NFPRHA is concerned that the proposed rule provides too much flexibility to states in the adoption of authorization and other utilization control measures, including policies that promote the use of generic drugs, creating a barrier to necessary family planning supplies for Medicaid enrollees. As previously stated, women need access to the full range of contraceptive methods in order to choose and utilize the method most effective for them.

Researchers have repeatedly concluded that even low prescription drug copayments cause very low income people not to fill the prescriptions their doctors have given them to treat their health conditions. In Oregon, after $2 generic and $3 brand name copayments were imposed, utilization of necessary prescription drugs declined by 17%, with reductions across every therapeutic category studied and with the greatest reductions occurring for drugs treating depression and respiratory diseases. (See Daniel Hartung et al., "Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-Service Medicaid Population," 46 MED. CARE 565 (2008)). A study in Minnesota found that when the State imposed tiered copayments of $1 for generic drugs and $3 for brand name drugs—far below those in the proposed regulations—slightly more than half of Medicaid patients using a public hospital reported being unable to fill prescriptions because of cost sharing. (Melody Mendiola et al. "Medicaid Patients Perceive Copays as a Barrier to Medication Compliance," Hennepin County Medical Center, Minneapolis, MN, presented at the Society of General Internal Medicine national conference, May 2005 and American College of Physicians Minnesota chapter conference, Nov. 2004).

If applied to the family planning context, the proposed $8 non-preferred drug copayment would ignore the reality that different contraceptive methods – whether they be brand name, generic, hormonal, non-hormonal, pill, intrauterine device, etc. – work differently for different people. The proposed rule does not contemplate the physiological, economic, social, and other factors that make a contraceptive method more or less effective for each woman.

As previously stated in these comments, neither states nor plan issuers should be given the latitude to decide which preventive health benefits, including specific family planning services or supplies, are most effective for the plan enrollees. NFPRHA urges CMS to clarify that family planning supplies are exempt from differential cost-sharing for non-preferred drugs.

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We appreciate the opportunity to comment on the proposed rule. If you require additional information about the issues raised in these comments, please contact Robin Summers at 202-286-6877.

Sincerely,

Clare M. Coleman

Clare Coleman
President & CEO