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February 19, 2019

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
Attn: CMS-9926-P
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically

**RE: CMS-9926-P; Medicaid Program; Patient Protection and Affordable Care Act;
HHS Notice of Benefit and Payment Parameters for 2020**

Dear Administrator Verma:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit the following comments on the Centers for Medicare and Medicaid Services' (CMS) proposed Notice of Benefit and Payment Parameters for 2020. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

Through a collaborative process with the patient, family, and other members of the health care team, the therapist develops goals and a plan of care to address the evaluation findings and specific needs of the patient. The physical therapist executes that plan of care by providing skilled techniques and procedures designed to optimize movement and function. Evidence-adherent physical therapy is an essential component in reducing the risk of adverse

events including functional decline, falls, progression of pain or the long-term need for pain medication, avoidable surgical procedures and/or hospitalizations, and disability.

APTA is committed to advancing the safety and quality of health care, and is eager to work collaboratively with the Department of Health and Human Services (HHS) and the states to promote access to appropriate, value-based services.

As CMS works to implement the policies proposed in this rule, we strongly urge the agency to consider the following recommendations:

Recommendations

- APTA recommends CMS require issuers provide enrollees with timely access to information about deductible progress, co-pays, co-insurance, prior authorizations and visit limits before they visit their provider.
- APTA recommends CMS continue to allow automatic re-enrollment of beneficiaries on the Exchange, and increase outreach and public awareness to ensure correct reporting of financial information that determines government spending, such as premium tax credits.
- APTA recommends CMS allow issuers to add generic drugs to their formulary mid-year but strongly opposes the proposal to allow issuers to remove drugs from the formulary at any time other than at the beginning of a new plan year.
- Should CMS allow issuers to remove prescriptions from the formulary or place the drugs in a more expensive tier, APTA recommends CMS require issuers provide at least 120 days' notice to enrollees as well as perform pharmacist outreach.
- APTA recommends CMS not finalize its proposed rule eliminating the requirement that Navigators perform certain post-enrollment activities.
- Should CMS finalize its proposals related to Navigators, APTA strongly recommends CMS continue to offer training on post-enrollment activities to ensure Navigators who choose to perform these roles have adequate training.
- APTA recommends CMS finalize as proposed the special enrollment period, allowing off-Exchange individual market enrollees who experience a decrease in household income to enroll in on-Exchange coverage.
- To avoid unfair premium increases on persons not receiving the benefit of cost sharing reductions (CSR), we recommend CMS continue to allow Silver Loading.
- APTA recommends CMS enforce the prohibition on nondiscrimination as it relates to medication-assisted treatment (MAT) and encourage issuers to offer interdisciplinary, nonpharmacological options for the treatment of pain to combat the opioids crisis.
- Finally, APTA recommends CMS continue to encourage issuers to implement measures aligned with the Meaningful Measures Initiative and continue to develop those measures with stakeholder input.

Enrollee Cost-Sharing Transparency

CMS requests comments on ways to further implement 45 CFR §156.220(d), enrollee cost-sharing transparency, where a Qualified Health Plan (QHP) issuer must make available the amount of enrollee cost sharing under the individual's plan or coverage for the furnishing of a

specific item or service by a participating provider in a timely manner upon the request of the individual. Specifically, CMS requests what types of data would be most useful to improving consumers' abilities to make informed health care decisions, including decisions related to their coverage.

APTA encourages CMS to increase cost-sharing transparency for consumers. Too often it is exceedingly difficult for consumers to determine what their actual out-of-pocket costs will be until they receive their bill. While uniform plan documents like summaries of benefits and coverage are important tools for consumers to compare plans while shopping, it is critical that consumer information does not cease once they have enrolled in a plan. Consumers need real-time information about deductible progress, co-pays, co-insurance, prior authorizations, and visit limits before they see their provider, not after a service is rendered and the patient is left with the bill. Issuers are the only party with access to all of this information. Accordingly, they should be responsible for furnishing consumers and providers with this information as soon as is possible so consumers may utilize their benefits and make informed care decisions without surprise expenses.

Automatic Re-Enrollment Processes

CMS seeks comment on the automatic re-enrollment process, specifically on additional policies or program measures that would reduce eligibility errors and potential government misspending. CMS notes that automatic re-enrollment can result in consumers being less aware of their plan options as well as potential eligibility errors, tax credit miscalculations, and unrecoverable federal spending on the credits.

APTA strongly supports continuing the automatic re-enrollment process. Automatic re-enrollment is the industry standard in the individual and small group markets, employer-sponsored coverage, and government sponsored plans like Medicare. CMS states that 1.8 million consumers in states using the federal platform automatically re-enrolled for plan year 2019 coverage. HHS also states that automatic re-enrollment significantly reduces issuer administrative expenses and makes enrolling in health insurance more convenient for the consumer. To end automatic re-enrollment would have dire consequences, as too many consumers rely on it to ensure they have continued coverage.

In order to address CMS's concerns with the accuracy of consumers' premium tax credits, APTA suggests CMS utilize its enrollment advertising budget, which the agency drastically cut in 2017. The \$90 million no longer used for open enrollment advertising could be used to educate consumers about the importance of updating their personal and financial information annually and notifying them of new plan options on the exchange. Rather than ending an industry practice that consumers have relied upon since the very beginning of the Exchange, CMS should utilize other options to ensure accuracy of information without risking loss of coverage.

Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

APTA supports CMS's efforts to address the constant increase in prescription drug expenditures. However, we encourage CMS to balance the interests of consumers and issuers and ensure adequate consumer protections are included in the final rule. CMS's proposal to allow plans to make formulary changes during the plan year when a generic equivalent of a prescription drug becomes available on the market has the potential to positively impact premium prices by allowing issuers to react to the changing prescription drug market in a more timely fashion. Giving plans greater flexibility to add less expensive drugs to their formularies without having to wait for a new plan cycle will speed the rate at which innovation can affect price. Accordingly, APTA strongly supports the proposed rule to the extent it allows for increasing the number of drugs in a formulary in a given benefit year.

However, CMS's proposal to allow plans to remove existing drugs from the formulary, or move them to a more expensive tier, could result in negative impacts to consumers, both financially and health-wise, that may outweigh the benefits of the proposed rule. First, health insurance policies are contracts purchased on an annual basis. Most consumers, regardless of their prescription needs, shop for plans with the understanding they are signing an annual contract, and the benefits they purchase will not change mid-year. This principle is codified in 45 CFR §147.106(e), which clearly states that only at the time of coverage renewal may issuers modify the health insurance coverage for a product. Furthermore, the consumers most likely to be negatively impacted by these changes are those who already rely on certain prescription drugs. They are savvy to the drugs they need, and often choose a plan because it not only covers their medications, but does so with a cost-sharing arrangement they can afford. Allowing plans to remove drugs mid-year or make them more expensive for consumers has life-threatening consequences for patients and contradicts consumer expectations, basic contract principles, and the text of the Patient Protection and Affordable Care Act (ACA) itself.

In addition, issuers are still able to reap savings by adding lower cost drugs to their formulary without removing existing drugs. There are other mechanisms available to drive consumers towards low-cost prescription products without completely removing coverage for the alternatives. Furthermore, removing a drug from a formulary mid-year only reduces costs for the issuer; the beneficiary's premium will not be reduced until the following benefit year, if it is reduced at all. It is inequitable to force the consumer to suffer a reduction in benefits which is not reflected in their premium price. Accordingly, APTA does not support allowing issuers to remove drugs from the formulary or to move drugs to a different tier in the formulary during a benefit year. Rather, we recommend CMS allow issuers to add drugs to the formulary mid-year, but only permit their removal or change in tier level at renewal.

Should CMS finalize the proposed rule to allow issuers to change the tier or completely remove coverage for certain drugs mid-year, APTA strongly encourages the implementation of robust notice requirements. Rather than the 60 day notice proposed, we suggest CMS implement a 120 day notice as well as require issuers to notify pharmacies of any formulary changes. Many consumers only truly learn of changes to their prescription drug benefits when they are at the pharmacy attempting to use those benefits. Furthermore, because many

consumers utilize 90 day prescriptions, a 60 notice may not give all consumers adequate forewarning that their drug of choice is no longer offered or is more expensive. Should a 120 day notice be combined with adequate pharmacist education, the maximum number of consumers will be warned that their formulary is changing, and they will have adequate time to take action if needed.

E. Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

Navigator program standards (45 CFR §155.210)

CMS proposes to remove the requirement that Navigators be trained in and provide assistance to consumers in certain post-enrollment activities, such as the process of filing Exchange eligibility appeals, applying for exemptions, the premium tax credit reconciliation process, certain tax considerations, and the basic concepts and rights related to health coverage and how to use it. While CMS would still allow Navigators to perform these functions, they would no longer be required and training for such activities would also be optional.

APTA strongly urges CMS not to move forward with its proposed changes to the Navigator program. The program is a valuable consumer assistance tool that helps individuals make informed decisions regarding coverage and health care, both while shopping for a plan and utilizing it. It is critical that consumers have access to experts in order for them to successfully navigate the complicated healthcare system. Navigators were created to ensure consumers would not be limited to insurance agents and producers for health care advice. Expert guidance is needed not just during enrollment, but also post-enrollment, to help consumers utilize the benefits they have purchased. To limit the role of Navigators to enrollment activities effectively renders them insurance producers, and denies consumers a critical resource in maximizing their benefits.

Therefore, rather than stripping away consumer marketplace assistance tools, APTA recommends the agency enhance the breadth and scope of the Navigator program. This would help ensure consumers, and small businesses and their employees have the necessary assistance to adequately review and understand their health coverage options, as well as complete eligibility and enrollment forms. Should CMS finalize this rule as proposed, we strongly encourage the agency continue to include post-enrollment activities in Federally Facilitated Exchange (FFE) Navigator training for annual certification or recertification. Otherwise, FFE Navigators may not even have the option to provide such services, as they will not have received adequate training.

Special enrollment periods (45 CFR §155.420)

CMS proposes to provide a special enrollment period to allow off-Exchange individual market enrollees who experience a decrease in household income to enroll in on-Exchange coverage when they receive a new determination of eligibility for advanced premium tax credits (APTC) by an Exchange. This special enrollment period is already available to persons enrolled in employer-sponsored coverage and is being extended to those in off-exchange coverage. APTA strongly supports this proposal. Any person who has maintained minimum essential coverage and experiences a drop in income sufficient to make them

eligible for APTC should be afforded an opportunity to enroll in the exchange, regardless of how they obtained their previous minimum essential coverage.

Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

Silver Loading

CMS requests comments on ways in which it might address silver loading until such time as Congress appropriates funding to continue CSR payments. APTA encourages CMS to allow silver loading to continue until CSR funding is appropriated. The increase in premium price for plan year 2019 was directly related to insurers not being compensated for offering statutorily required CSR. As CSR is only available for silver level plans, the increase in premium should be tied to these plans. Silver loading is the only equitable way to distribute the premium increases which resulted from the discontinuation of CSR funding. While APTA ultimately supports appropriate funding of these payments, until Congress takes action, consumers not receiving the benefit of CSRs should not be forced to bear their cost.

Prohibition on discrimination (45 CFR §156.125)

CMS raises concerns regarding the coverage of medication-assisted treatment (MAT) for opioid use disorder, and the potential for discriminatory benefits which do not cover MAT drugs for opioid disorder but do cover the same drugs for other medically necessary purposes. APTA supports CMS's continued effort to address the opioid crisis and prevent discriminatory benefit design. However, we encourage CMS to examine other areas of inequitable benefit design which will address the opioid crisis. Beneficiaries need early access to nonpharmacological interventions, including physical therapy. To promote early intervention, CMS could instruct QHP issuers to waive copayments for initial visits, early or no referral requirements for conservative therapies, and direct contracting with employers to ensure early access to conservative therapies. Patients need an integrated team approach that focuses on pharmacological and nonpharmacological multidisciplinary management and interventions for acute pain to decrease the potentially disabling effects of chronic pain. CMS should examine the benefits of multidisciplinary treatment models for patients with pain and addiction, and consider how such models can be more widely adopted. Interdisciplinary, comprehensive pain-management models that evaluate and treat the different factors influencing the presence of pain will enhance the effectiveness, efficiency, and safety of the care delivered.

Additionally, there must be appropriate reimbursement for a broad range of pain management and treatment services, including nonpharmacological treatment options, such as physical therapy. This sentiment was expressed by the President's Commission on Combating Drug Addiction and the Opioid Crisis in its final report, recommending that "CMS review and modify rate-setting policies that discourage the use of non-opioid treatments for pain, such as certain bundled payments that make alternative treatment options cost prohibitive for hospitals and doctors, particularly those options for treating immediate post-surgical pain."¹

¹ The President's Commission on Combating Drug Addiction and the Opioid Crisis. Final Report. https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf Accessed July 8, 2018.

Premium adjustment percentage (45 CFR §156.130)

CMS proposes to use an alternative premium measure for purposes of calculating the premium adjustment percentage for the 2020 benefit year and beyond. In previous years, CMS used a methodology based on per enrollee employer-sponsored insurance premiums, as they were more reflective of actual health care costs and not subject to the fluctuations of the individual market, which were exacerbated by the implementation of the ACA. CMS is now proposing to begin calculating the premium adjustment percentage on an adjusted private individual and group market health insurance premium measure.

APTA has serious concerns with the timing of this change. While we support CMS's intent to eventually tie the premium adjustment percentage to the individual market, the individual market has not yet stabilized enough to pin such an important factor to its fluctuations. For example, the recent end to CSR funding resulted in a large increase in premiums not due to market factors but instead due to a change in administrations. Further, at a time when many consumers are still struggling to afford coverage, it is inappropriate to institute this unnecessary change that will result higher premiums for 7.3 million people.²

CMS indicates one motivation for the change is to slow the rate of APTC growth caused by silver loading practices. However, in order to reduce government spending on APTC, APTA recommends CMS seek to reduce premium prices, namely by resuming CSR payments to issuers. This will solve the problems of silver loading and increased APTC payments by lowering premiums rather than by reducing assistance to consumers.

Quality Standards (45 CFR §§156.1120, 156.1125, 156.1130)

APTA appreciates that within the proposed rule, the agency encourages QHP issuers to use performance measures aligned with the Meaningful Measures Initiative when implementing their Quality Improvement Strategy providing increased reimbursement or other market-based incentives for improving health outcomes of consumers. APTA supports CMS's Meaningful Measures Initiative. APTA believes that the meaningful measures framework will ultimately benefit clinicians, patients, and payers, as it will streamline measure development and ensure that measures that are the highest priority are included in quality programs. We urge CMS to work with stakeholders, including APTA, to advance measurement systems that reflect real-world indicators and outcomes and to implement these programs across health care systems to lower burden on providers and issuers alike. We recommend CMS continue to solicit input to further improve the framework.

Conclusion

APTA thanks CMS for the opportunity to comment on the Notice of Benefit and Payment Parameters for 2020. We look forward to being a vested partner with CMS as we work toward the common goal of ensuring consumers have access to high-quality, affordable health care. Should you have any questions regarding our comments, please Kate Gilliard,

² Aviva Aron-Dine and Matt Broaddus "Change to Insurance Payment Formulas Would Raise Costs for Millions With Marketplace or Employer Plans" Center on Budget and Policy Priorities, January 18, 2019 <https://www.cbpp.org/sites/default/files/atoms/files/1-18-19health.pdf> (Accessed February 7, 2019)

senior regulatory affairs specialist, at 703/706-8549 or kategilliard@apta.org. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Sharon L. Dunn". The signature is written in a cursive, flowing style.

Sharon L. Dunn, PT, PhD
Board-Certified Orthopaedic Clinical Specialist
President

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