Comments on the Medicare + Choice Interim Final Regulations Pertaining to Reproductive Health and Advance Directives

September 24, 1998

Health Care Financing Administration
Room 309-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Comments on the Medicare + Choice Interim Final Regulations Pertaining to Reproductive Health and Advance Directives
File Code: HCFA - 1027

To Whom It May Concern:

The National Health Law Program and Medical Students for Choice submit the following comments in response to the Interim Final Regulation to establish the Medicare +Choice program, published in the Federal Register on June 25, 1998. Our comments are limited to those provisions that pertain to reproductive health and advance directives. The National Health Law Program also has endorsed the comments submitted by the National Partnership for Women and Families.

Access to reproductive health services generally is not considered an important issue in the Medicare program. However, well over half of all Medicare beneficiaries (57%) are female and 12% are under age 65. Furthermore, access to reproductive health services remains important for women even if they are no longer of child bearing age. Accordingly, we urge HCFA to adopt the following comments:

I. Application and Contracting

Medicare beneficiaries are entitled to a certain benefits package. In addition, health plans are permitted to provide additional benefits. In evaluating applicant health plans, HCFA should ensure that beneficiaries have access to the full scope of services to which they are entitled including all reproductive health and abortion services. In addition, HCFA should favor those health plans that provide a more complete package of services.

Section 422.6 Application Requirements

Non-religious health plans that contract with religious hospitals, medical groups, or other religious health entities should explicitly state in their application to HCFA how they will make alternative, geographically accessible, and medically appropriate avenues for Medicare beneficiaries to obtain the

full scope of reproductive health services in an integrated and coordinated manner.

Section 422.516 Reporting Requirements

Subsection (b) requires health plans to report to HCFA certain information when a significant transaction has occurred. Information reported to HCFA should include any limitations on services that result from the transaction, including limitations on access to reproductive health services.

II. Enrollment and Disenrollment

Beginning in 2002, disenrollment will be limited increasingly, until individuals are locked-in for a full year. Beneficiaries who are enrolled in health plans that restrict services due to religious or moral beliefs should have more flexibility to disenroll as follows.

Section 422.62

Subsection (b) specifies the circumstances under which individuals who are locked-in can disenroll. This section should be amended to include as a circumstance for disenrolling:

- an individual's inability to obtain *timely* family planning services;
- an individual's receipt of a notice from the health plan (as required under 422.111(d)) indicating that the health plan will no longer provide certain services or honor legal provisions specified in advance directives, including because of moral or religious beliefs.

There should be no lock-in if the only M+C plans available in a geographic are those that have religious or moral objections to the full scope of family planning and/or will not honor legal advance directives. There also should be no lock-in if the only M+C plan options in a geographic area limit hospital and/or outpatient services to entities that are religiously owned or operated and which have religious or moral objections to the provision of services that otherwise are covered by Medicare.

III. Informing and marketing

In order for beneficiaries to be able to make an informed choice in the new "marketplace of options" (63 Fed. Reg. 34890), it is imperative that they are informed about the benefits that are and are not available to them in each health plan. Because of certain health plans' and providers' religious and moral beliefs, certain benefits may not be available that otherwise must be covered under Medicare. In addition, legal terms included in individuals' advance directives may not be honored if they are deemed to conflict with these entities' religious and moral beliefs. Medicare beneficiaries should be informed about any such restrictions on their services and treatment. Therefore, we urge HCFA to ensure that such information is made available to Medicare consumers so that they can "evaluate M+C options and make informed choices based on their individuals needs" (63 Fed. Reg. 34981) and beliefs.

Section 422.64 Information About the M+C Program

As part of the description on benefits and providers, health plans should be required to provide HCFA with information on what services, if any, they refuse to provide, furnish, or pay due to religious or moral beliefs. This should include family planning or other reproductive health services and a refusal to honor any legal terms in advance directives.

In the case of non-religious health plans contracting with religious hospitals or other facilities, information should be made available about any limitations on access to services due to religious or moral beliefs at those facilities and in the health plan as a whole.

This information should be made prominently available to Medicare beneficiaries in comparative informational materials made available by HCFA, including on HCFA's consumer website.

Section 422.80 Approval of Marketing Materials

As part of HCFA's guidelines (subsection (c)) to review of marketing materials, HCFA should specify that marketing materials should inform individuals about any restrictions on services due to religious or moral beliefs. This includes any restrictions on reproductive health services and any objection to carrying out any legal term that can be included in advance directives.

Also, a description of the main providers and health facilities in a geographic area should be provided (e.g., hospitals, major medical groups). In this description of provider networks, health plans should indicate which, if any, hospitals, health facilities, or major medical groups are religiously affiliated and what services are restricted at sites due to any religious or moral beliefs.

Section 422. 111 Disclosure Requirements

This section lists those items which health plans must disclose to each enrollee electing the health plan and annually thereafter. Changes in rules must be provided 30 days before the date of the change. This section should be amended to require disclosure of this information to individuals before they enroll. Moreover, subsection (b)(2) should clarify that information on limitations on benefits includes limitations due to religious or moral objections. This information specifically is required to be provided by 422.206(b)(2)(iii) to current members 30 days prior to and 90 days after a health plan changes its rules.

Disclosure also should include an explanation under subsection (b)(3) of any major providers or health facilities (e.g., hospitals, clinics, medical groups) which restrict access to services based on religious or moral objections and how individuals are to otherwise obtain these services.

This section also requires that health plans disclose members' disenrollment rights and responsibilities. Disclosure on disenrollment should include information on ones ability to disenroll when notified that a health plan or its provider network no longer will provide access to reproductive health services or honor any legal terms in an advance directive as proposed below in the discussion on enrollment and disenrollment.

Finally, subsection (e) requires plans to inform members of changes in its provider network. Such information should include any restrictions on services that result from such changes (e.g., if the health plan now only contracts with a religiously affiliated hospital).

Section 422.104 Special rules for point of service option

Subsection (d)(2) requires that point-of-service plans provide beneficiaries with an "evidence of coverage" document. The information in this document should include any limitations on services due to the religious or moral beliefs of religious health care entities in the provider network.

Section 422.128 Information on Advance Directives

This section requires health plans to document and maintain advance directives prominently in the members' medical file. This section should be amended to require the health plan and its contracting hospital(s) in its service areas and promptly inform the beneficiary whether or not there are any provisions with which the health plan or hospital will not comply die to religious or moral objections. Upon such review and notice to the member, the member should be informed of his or her right to disenroll from the health plan and allowed to disenroll if the member disagrees with the health plans' and/or hospital(s) policy.

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IV. Access and Continuity of Care

Section 422.112 Access to Services

Subsection (a)(1)(i) requires health plans to "maintain and monitor a network of appropriate providers ... to provide adequate access to covered services to meet the needs of the population served." This subsection should be amended to clarify that when a non-religious health plan contracts with religious hospitals and other entities, they must make available alternative, accessible, culturally and linguistically appropriate services that the religious entities in its network refuse to provide. If these services are not available in-plan, then the non-religious health plan should be made to help beneficiaries access and pay promptly for services out-of-plan.

Subsection (a)(1)(iii)(A) requires health plans to allow women to select women's health specialists within the network for routine and preventive care. We support this rule.

Section 422.114 Access to Services under a M+C private FFS plan

Subsection (a) requires a private FFS plan to demonstrate to HCFA that the plan has sufficient number and range of providers willing to furnish services under the plan. This section should be clarified to require non-religious private FFS plans to demonstrate (where they have contracted with religious hospitals and other entities) that they have alternative, geographically accessible, and medically

appropriate means for members to obtain these services in an integrated and coordinated manner.

V. Interference with Health Care Professionals' Advice to Enrollees

Section 422.206

We support and adopt the comments submitted by the National Partnership for Women and Families. In addition, we note that this rule must be amended to clarify that the conscience clause applies only to bona fide religious entities as recognized by the IRS.

VI. Quality Assurance/External Review

Certain health plans will be permitted to refuse to cover, furnish, or pay for services against which they have moral and religious objections. This does not mean that Medicare beneficiaries do not need these services or that refusal of these health plans to provide these services will not have a health impact on beneficiaries.

Sections 422.152, 422. 154

HCFA should monitor the health status of Medicare beneficiaries in these health plans very closely. HCFA should devise health indicators (including consumer survey questions as part of CAHPS) which are related to lack of access to reproductive health and to require the health plans to collect and report that data. In addition, HCFA should monitor and report instances in which legal terms in advance directives are not followed. Such data should be made available with the other performance measures.

Such indicators also should be made part of the external review and the HCFA on-site review of health plans.

Thank you for the opportunity to comment on these regulations.

Sincerely,

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