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December 22, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9944-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE:

CMS-9944-P

RIN 0938-AS19

**Patient Protection and Affordable Care Act; HHS Notice
of Benefit and Payment Parameters for 2016**

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to protect health rights and advance access to comprehensive, quality health care for low-income and underserved people. The oldest non-profit of its kind, NHeLP advocates, educates, and litigates at the federal and state levels.

We appreciate the opportunity to provide comments in response to HHS's proposed regulation "Notice of Benefit and Payment Parameters for 2016." Our comments support many provisions of the proposed regulations which improve access to coverage for vulnerable individuals, and we make some specific recommendations to improve the regulation.

**Exchange Establishment Standards and Other Related
Standards Under the Affordable Care Act**

*§ 155.205 – Consumer assistance tools and programs of an
Exchange*

We support the proposed regulation requirement that QHP issuers and agents and brokers provide oral interpretation services in at least 150 languages utilizing an over-the-phone interpreting agency (OPI). We believe this is important movement towards providing meaningful access to Exchange coverage to individuals

with limited English proficiency (LEP). Title VI of the Civil Rights Act of 1964 prohibits any recipient of federal funds from discriminating on the basis of race, color or national origin, and this includes discrimination based on LEP. Furthermore, section 1557 of the Affordable Care Act also prohibits discrimination by federal fund recipients as well as by any entity created under Title I of the ACA and any program administered by a federal agency. This means QHP issuers and agent and brokers, operating in state-based Exchanges or the federally facilitated Exchanges, must have clear plans and services in place to meet the language needs of consumers with LEP. Providing telephonic language services in at least 150 languages is a good start.

We also recommend that HHS emphasize that this requirement does not limit or abrogate requirements under Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. HHS' LEP Guidance describes requirements of entities covered by Title VI and it does not limit oral interpreting to any number of languages. Thus, while an entity covered by this regulation would have to contract with an OPI for at least 150 languages, if the same entity is governed by Title VI and Section 1557, it would have to provide oral interpreting in any language even if not one of the 150 covered by an OPI company. Many of the entities covered by this provision are also subject to Title VI and Section 1557 because they receive federal funds. So it must be clear that this provision sets a floor but not a ceiling on providing language services.

In addition, to ensure no individual is discriminated against, these entities should be required to develop language access plans that describe how they will serve consumers whose needs go beyond this language floor. We also strongly recommend the OPI contracts are not limited to 150 languages if the OPI company can provide additional languages. Further, an entity may have a specific need, on a case-by-case basis, for an additional language on the rare occasions they need to serve a consumer in a language that falls outside of the 150 languages.

Further, we recommend that HHS provide guidance on how to select a competent OPI company. Best practices for ensuring competent oral interpretation may be taken from the Certification Commission for Healthcare Interpreters (CCHI)¹ and the National Board of Certification for Medical Interpreters,² both of which use standards established by the National Council on Interpreting in Health Care.³ Additional guidance and best practices are provided in Standards 5 and 7 of the enhanced National CLAS Standards,⁴ as well as the HHS LEP Guidance.

Many OPI companies exist but not all have interpreters who have been trained and are competent to interpret in the healthcare arena. There is significant specialized

¹ Certification Commission for Healthcare Interpreters, <http://www.healthcareinterpretercertification.org>.

² The National Board of Certification for Medical Interpreters, *Certified Medical Interpreter Candidate Handbook 2013–2014*, <https://www.certifiedmedicalinterpreters.org/sites/default/files/national-board-candidate-handbook-2013.pdf> (last accessed Sept. 17, 2013).

³ National Council on Interpreting in Health Care, *National Standards of Practice for Interpreters in Health Care*, <http://www.ncihc.org/assets/documents/NCIHC%20National%20Standards%20of%20Practice.pdf>.

⁴ Office of Minority Health, U.S. Dep't of Health & Human Servs., *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice* (2013).

terminology involved in the activities of insurers, agents and brokers that differ from specialized terminology used in legal settings, community interpreter settings, and other settings. It is thus important not only that these entities engage an OPI company but specifically that they contract with one that will be competent to provide interpreting for the specific types of interactions that will be needed. The California Endowment commissioned a report a number of years ago which could be helpful – ***How to Choose and Use a Language Agency: A Guide for Health and Social Service Providers Who Wish to Contract with Language Agencies.***⁵

We are concerned that the proposed rule does not extend this requirement to navigators and non-navigators. While we recognize that navigators and non-navigators are subject to requirements to provide language assistance pursuant to Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act as well as their governing regulations, we also believe that these entities should be subject to this specific requirement to provide telephonic language assistance. The preamble expresses concern that having a requirement to provide oral interpretation in at least 150 languages may be prohibitive to some small not-for-profit agencies serving as navigators and non-navigators. We strongly believe these groups should strive to hire skilled, bi/multi - lingual staff that meets the greatest language needs of the communities served. But for less frequently encountered languages, or smaller agencies for whom having bi/multi-lingual staff is not possible, requiring access to competent telephonic interpretation may actually be the most efficient and cost-effective method of providing language services. Further, most OPI companies only charge a minimal per-monthly amount and then by the minute so if a navigator does not need the OPI's services, it will not be subject to significant cost.

Thus we believe HHS should require these entities to provide oral language services in at least 150 languages. But recognizing HHS' concerns, we believe HHS also can assist these entities in meeting this requirement. For example, HHS could initiate a contract with a reputable OPI company and assign unique codes for navigators and non-navigator personnel to use in accessing a centralized language line service. By having a large contract, HHS could negotiate a cheaper per minute fee making this vital service more affordable (while also relieving these entities of having to individually investigate and contract with a language line). For example, many OPI companies now offer services for less than \$1/minute, particularly for high-volume contracts. HHS could also allow these entities to include the costs of providing language services in their budgets to either contract with an OPI company or to pay the costs of using a HHS-contracted OPI company. Alternatively, HHS could allow navigators and non-navigator personnel to access the Exchange call center's language line to provide language services to consumers. This alternative is not ideal because it requires more resources, if a call center operator must be involved for an assister to access the language line. Regardless of how it is operationalized, the final rule should ensure that navigators and non-navigator personnel do not turn away or delay services to individuals seeking assistance simply because their staff cannot meet language needs and HHS should

⁵ http://www.calendow.org/.../how_to_choose_use_language_agency.pdf.

identify administrative strategies to help these groups meet the language needs of consumers.

Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

§ 155.222 – Standards for HHS-approved vendors of Federally-facilitated exchange training for agents and brokers

We are concerned about the provision allowing external entities to train agents and brokers rather than requiring use of HHS-provided training. The preamble to this provision of the rule does not adequately describe why there is a need for vendors to train agents and brokers other than to say the approach will leverage the experience, contacts, and networks of approved vendors. We are unsure that vendors will have sufficient expertise to train agents and brokers. It is also unclear why HHS believes alternate training would increase broker participation unless the training was shorter or easier than the required one and we do not believe HHS should allow reduced standards. The Exchanges are new and significant subject matter expertise is needed to provide appropriate training. We do not believe it is sufficient just to understand key aspects of plan design. Agents and brokers must understand the complex eligibility rules for Medicaid, CHIP and Exchange subsidies.

The regulation includes standards to ensure consistency in the content of training and requires HHS to monitor vendors. It will be important to ensure that HHS has sufficient capacity to evaluate applications and monitor the performance of vendors on an ongoing basis. While the proposed rule allows HHS to opt to revoke a vendor's ability to offer training and verification of vendors acting wrongfully, the impact of revocation is unclear: What would it mean for agents and brokers already trained/verified by the excluded entity? Will they be able to continue to serve consumers in the Exchange? If so, how would CMS ensure they had proper training and went through the appropriate verification process? How will they get ongoing technical support?

If HHS decides to allow vendors to provide training and verification of agents and brokers, the final rule should address how vendor conflicts of interest would be handled, specify how CMS will monitor vendors and ensure that their performance is adequate, and detail what would happen in the event that CMS revokes a vendor's ability to train and verify agents and brokers.

We are also concerned about the potential added costs. HHS' training is free while an external vendor would likely charge a fee, either limiting access or increasing the fees agents and brokers charge to recoup this cost.

If HHS proceeds with this proposal, we recommend ensuring that it only applies to training for agents and brokers and that HHS does not consider implementing a similar option for navigator and assister training. Many navigators and assisters are low-income themselves and employed part-time. Implementing any costs associated with training programs would greatly reduce the ability of individuals to serve as navigators and assisters.

§ 155.335 – Annual Eligibility Redetermination

We commend HHS for its careful consideration of how to prioritize consumer interests in the re-enrollment methodology. We agree that the optimal policy requires a balance between continuity of providers *and* affordability. We support an approach which includes a default policy based on balancing (described below), as well as an option for sophisticated consumers to select their re-enrollment hierarchy.

We recognize that there needs to be a default process for auto-renewing people who do not actively return to the Exchange to make plan choices during open enrollment. However, giving people the choice of being defaulted into a low-cost plan a year ahead of time does not address the critical need to develop effective ways to encourage consumers to play an active role in evaluating their plan choices each year. For example, HHS could develop the technology to allow the FFM to recommend plans that have similar features as an enrollee's current plan but are lower cost. Consumers may feel more compelled to shop for new plans if they were presented with such information. We also recommend that HHS improve the language of notices to enrollees. We believe that the notices developed for the 2015 open enrollment period were vague and confusing, and future notices need to more effectively convey the importance of returning to the Exchange to make plan choices and the consequences of not doing so. And as noted, in the future, the renewal process should provide people with notice of their updated eligibility determination as set forth in the original rule at 45 CFR §155.335.

Default Approach

As an initial matter, we note that consumers rarely prioritize continuity of an *issuer*. Consumers care about their providers and coverage policies. While some correlation may exist between continuity of issuers and providers/policies, this is not always the case. Therefore, we do not support an approach that prioritizes continuity of issuer, as the network and policies of a "similar" issuer plan may create a false sense of continuity. Instead, we believe continuity should be measured by providers and coverage policies, with continuity of primary care provider (PCP) being the simplest proxy for provider continuity (and recognizing that for some consumers, a primary care provider may indeed be a specialist such as women whose gynecologist serves as a PCP or individuals with disabilities who may have a specialist providing the primary source of care).

In terms of affordability, we believe most consumers will be willing to absorb *modest* price increases to stay in the same plan (again, this means same providers, not same issuer). We are supportive of the concept of HHS using a premium growth threshold to trigger changing the plan assignment. We recommend the use of a three tiered re-enrollment hierarchy similar to the following:

1. Consumer remains in current plan (again, not just issuer) if the plan's premium does not increase more than 10%.
2. If current plan increases more than 10%, consumer is enrolled into the lowest cost plan of the same metal tier *that includes the consumer's primary care provider*, assuming (1) the new plan is at least 10% less than the new cost of current plan, and (2) the new plan is not 20% more than the current cost of the current plan.
3. If there is no plan within 20% of the current plan that includes the individual's primary care provider, the individual is enrolled in the lowest cost plan of the same metal tier level (including plans that do not include the primary care provider).

Of course, the above automatic hierarchy would only be implemented if a consumer did not directly make her choice after the normal process of notice of change and plan selection. We note that, while plan premium is an important indicator of cost, it is not the only indicator, considering cost-sharing and other costs absorbed by consumers. Therefore, the above hierarchy would ideally find a way to factor in these other costs when evaluating affordability. Finally, we note that the above hierarchy would only rely on random assignments when two or more plans were tied as the lowest cost plan(s).

Choice of Re-enrollment Hierarchy

We are supportive of a re-enrollment hierarchy choice for consumers, assuming HHS has a simple way to implement it that will not overly burden less sophisticated consumers. At the time of application many consumers will know whether they have pressing provider or financial needs which will inform their re-enrollment priorities. Allowing consumers to heavily weight continuity of plans and providers (not issuers) or continuity of cost in their re-enrollment will reduce administrative hassle for consumers and the system as a whole.

Issuer Incentives

We believe that a hierarchy emphasizing continuity of providers (not issuers) and cost produces the best outcomes for consumers. Issuers will have an incentive to keep network disruptions and premium growth minimal to assure retention of their enrollees. In contrast, a system prioritizing issuer continuity is only slightly helpful to consumers *and* reduces the disincentive for issuers to constantly change their offerings, since they can retain customers despite fluctuation. We note, finally, that as HHS identifies the stability of the enrollment hierarchy, the percentages should be adjusted downward to further incentivize issuers to keep their offerings consistent.

State-based Hierarchies

We believe HHS should work with states to promote similar hierarchies prioritizing provider (not issuer) and cost continuity. While we are broadly supportive of states having implementation flexibility (for example, the percentage thresholds might be

higher or lower in states with more or less historical premium fluctuations), we do not believe HHS should authorize states to prioritize issuer continuity as this rule is finalized for future years. Large and powerful issuers may have undue influence in state insurance regulation, and prioritizing issuer continuity may reward issuers who resort to tactics reminiscent of “bait and switch”, while at the same time blocking enrollments for issuers who work hard to deliver affordable products with wide networks. We therefore believe the above hierarchy prioritizing continuity of providers and costs should be the national standard which states have flexibility to calibrate but not re-design.

Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

§ 155.400 – Enrollment of Qualified Individuals Into QHPs

We are very supportive of the development of a standardized policy for setting deadlines for payment of first month premiums. Such a policy will benefit consumers by generally reducing confusion, and this will be particularly true for consumers who transition from one plan to another or who have individuals enrolled in different plans in their household. This will also greatly simplify messaging for Exchanges, government agencies, plans, and the assister community. We also believe this will benefit issuers in the long run, as they will be more likely to receive timely payments if all consumers have a clear understanding of payment schedules.

For regular effective dates, we are supportive of a payment deadline policy that, at a minimum, ensures consumers will have 30 days to make payments and is not earlier than the coverage effective date. If consumers are required to pay long in advance of effective coverage it will create confusion, particularly for the many consumers who are purchasing their first health insurance product ever.

Adding additional time after the coverage effective date (such as 15 days) for the payment deadline will benefit many consumers who will be struggling with the administrative and financial steps needed to make their first payment, and we support such a proposal. However, we are also concerned that additional days may increase the risk of consumers being charged for accidental coverage. For example, a consumer might fully initiate the enrollment process intentionally, unintentionally, or due to plan error, and then never make payment. In such a situation, we are concerned the individual would be subject to billing for the coverage period. Therefore, we urge HHS to not implement any system whereby individuals could accidentally be charged for additional time. We believe the ideal policy is one where the consumer has some additional time (15 days), but the consumer is not liable for payment of that “coverage” if the consumer never makes payment as long as the consumer never used the coverage.

For non-regular effective dates (e.g., special enrollments), we support the development of a standardized premium payment deadline. However, we do not believe that date should be tied to the date an issuer receives transaction information. Instead the date should be tied to some amount of time after the consumer receives specific notice of the

payment obligation, including instructions for how to fulfill that obligation. This date too should not be a date prior to the effective date of coverage, and should also offer a 15-day additional time window as per our recommendation above. We recommend HHS therefore set the deadline as 30 days from the date the consumer receives specific notice of the payment obligation, including instructions for how to fulfill that obligation, or, 15 days after the effective date of coverage, whichever is later.

§ 155.410 – Annual Open Enrollment Period

We understand HHS' intent to simplify the open enrollment process by eliminating the portion of the open enrollment period occurring after January 1. However, we do not support such a change. We believe the window of time after January 1 is critical to capturing consumers who forgot to enroll on time or misunderstood the enrollment process. For example, there may be consumers who *thought* they were enrolled or renewed, and it will not be until January that they figure out they were not enrolled. The confusion created by extending the annual open enrollment period is less than the confusion in issuing special enrollments for such consumers, and of course some consumers will not qualify for any special enrollment. Finally we note that late November and December are heavy holiday periods, and deadlines in those periods may be difficult for consumers to track. We recommend that the annual open enrollment period end on January 31. As an alternative to an earlier end date, we suggest that HHS consider new strategies to publicly promote the deadline for effectuating coverage by January 1.

Regarding the start of open enrollment, we support the suggestion to move the date earlier – and we fully support the objective of enrolling as many individuals as possible prior to mid-December, to allow for easy January 1 transitions. We are supportive of October 1 as a start date.

§ 155.420 – Special Enrollment Periods

(b)(2)(i)

Current rules allow Exchanges to offer consumers qualifying for certain special enrollment periods (such as for birth) with an alternate eligibility date. The proposed rule changes the alternate eligibility date from the first of the following month to the standard Exchange enrollment timeframe (which might be the first of the following month or the second following month). Although we appreciate that, under the proposed rule, consumers retain their right to elect coverage as of the triggering date, in some situations consumers would only have a choice between the triggering date and the second following month, potentially leading to an unnecessary coverage gap. We believe the need to outweigh the harm caused by such a gap outweighs the administrative hassle short enrollment timelines create for individuals. We are aware of no reason why consumers might prefer to be uncovered in the first following month (and we expect that if the consumer has other coverage on the triggering date, it would most likely to end at the end of *that* month, and not the end of the first following month).

(b)(2)(iv) and (c)(2)

The revisions to § 155.420(b)(2)(iv) and (c)(2) allow individuals qualifying for an SEP based on a permanent move to initiate their SEP in advance of their move and secure coverage on the first day of the following month (starting in 2016). We strongly support this change to the regulation, as it will allow individuals to ensure that a change in permanent residence does not lead to a gap in coverage. We also urge HHS to reconsider the default policy in (b)(iv) for selections made after the triggering event. Many consumers will not understand the impact of a move on their health coverage, and thus will only realize the impact on their coverage once they have lost it. For such individuals who already have/had coverage, we urge HHS to remove any flexibility to effectuate coverage on the first day of the second following month (as may apply to new applicants), and instead require coverage to be effective on the first day of the month following the consumer's attempt to transfer coverage. We also recommend that CMS customize the notice requirements for disenrollment based on permanent move, so that consumers understand how to transfer coverage without a gap.

(b)(2)(v)

We support the provision to make coverage required by court order to be effective the first day of the following month, with the option for the consumer to choose standard enrollment time frames if those are preferable.

(b)(2)(vi)

We support the provision to make coverage following a death effective the first day of the following month, with the option for the consumer to choose standard enrollment time frames if those are preferable. However, the preamble to the regulation (at 70709) only includes an "expectation" that coverage will last until the end of the month, and offers the possibility of prorated coverage based on the death date. We believe that consumers coping with the death of a household member should be able to retain coverage for the duration of the month, as opposed to have to immediately address a potential coverage change. We recommend HHS require coverage for the duration of the month in circumstances of death for purposes of continuity and simplicity for grieving consumers. HHS could consider a retrospective proration system at the consumer's option (for example, if the consumer could reduce their net premium cost with the household change), assuming it can be administered with no additional burden for grieving families.

(d)

We urge the Department to add an additional special enrollment period for enrollees who become pregnant. Pregnancy should trigger a special enrollment period, enabling women to choose an appropriate coverage option. For example, if a woman holds coverage through a catastrophic plan that has a high deductible that applies to maternity services, she should have the option to change her coverage tier.

(d)(1)(ii)

We support the extension of the SEP created for non-calendar year plans to all years (in addition to the current exception for 2014). Consumers transferring from any one of a number of non-calendar year plans will need this SEP in 2015 and beyond.

(d)(2)(i)

We support the inclusion of new language to create an SEP when an individual gains or becomes a dependent due to any one of a number of life circumstances.

(d)(2)(ii)

We support the inclusion of new language to create an SEP when an individual loses or ceases to be a dependant due to any one of a number of life circumstances.

However, we are concerned that this does not go far enough; some women who are not enrollees in Exchange coverage also need access to a special enrollment period due to loss of dependent status after a legal separation, divorce, or death.

For example, a woman whose spouse's offer of employer-sponsored coverage is considered affordable based on worker-only coverage may remain uninsured if a family policy is too expensive for her family. If she becomes divorced or legally separated, she will no longer be eligible for minimum essential coverage (MEC) through her former spouse's employer, but will not qualify for a special enrollment period because she has only lost eligibility for MEC, not the coverage itself. Given her change in circumstances, she should qualify for a special enrollment period even though she was not previously enrolled in Exchange coverage. We urge the Department to expand these qualifying events to individuals who are not currently enrolled in Exchange coverage.

(d)(4)

We support the provision to allow an SEP for enrollment errors. We support the broad definition of the errors, including error, unintentional enrollment, misrepresentation, inaction, etc. We also support the application of this SEP to actions committed by Exchanges, their employees and agents, as well as non-Exchange entities including the full range of brokers and assisters that consumers rely upon. We believe this SEP and the breadth of its terms will give the most effect to the true and properly informed intent of consumers.

(d)(6)

We strongly support the creation of an SEP for individuals whose income increases from below 100% FPL to above 100% FPL. Such individuals should immediately be able to access Exchange coverage and subsidies, and their inability to enroll during the open enrollment period is clearly not their fault (in fact, many *tried* to enroll).

We support the addition of special enrollment periods in cases when people experience a death or divorce outside of the regular open enrollment period. We agree that a death or divorce, similar to a birth or a marriage, is a significant event that warrants giving individuals and families an opportunity to enroll in or change their health insurance

coverage. However, the proposed regulations extend the death and divorce special enrollment period only to people who are already enrolled in a qualified health plan. This is inadequate. We continue to urge HHS to establish a broader special enrollment period targeting people who experience a change in income or tax household that makes them newly eligible for advance premium tax credits. While the proposed SEPs for death and divorce, along with the new SEP for people formerly in the Medicaid coverage gap, improve access to advance premium tax credits and exchange coverage, they are not enough. Important groups of individuals will still be left out, such as people who are separated but still married during open enrollment but then divorce during the benefit year. The financial picture of the individual members of such a couple would look very different during open enrollment — when they are technically still married and their incomes must be considered together — compared to after open enrollment is over, when the couple’s divorce is final, and both people may become newly eligible for subsidies. Under the proposed regulations, such people could get a special enrollment period only if they were already enrolled in a qualified health plan, which may have been too expensive prior to the divorce, or if there is a loss of minimum essential coverage, such as when one member of the couple received health benefits through the employer of the former spouse. Moreover, we have been told that someone who was living apart from her spouse and knew she would be divorced during the year would be considered married at the time she applied. Therefore, she would have to include her husband on the application. In many cases, her husband’s income, which was not available to her, would make her ineligible. Once she got divorced, she could apply as single but she would need an SEP in order to access a qualified health plan and receive APTCs.

To address such situations, the final regulations should include within § 155.420(d)(6) an additional SEP for the situation when:

“A qualified individual or his or her dependent has a change in income, tax household composition, or tax household size resulting in a determination that he or she is newly eligible for advance payments of the premium tax credit.”

We recommend the above language as a permanent change to the regulations. For 2015, we also recommend extending an enrollment opportunity so that people who discover they owe a penalty for lacking health coverage during 2014 may enroll in 2015 coverage outside of open enrollment. Because the ACA has been implemented so recently, many people are unaware of the law’s requirement to have minimum essential coverage or to pay a penalty. Many also do not realize they could receive substantial financial help in obtaining coverage by applying for an advance premium tax credit. Tax filing season will greatly increase awareness of both the penalties and the subsidies, but many people will file their taxes after the close of regular open enrollment in the exchanges and will be unable to obtain coverage for 2015. An enrollment period running through April 15 would allow people who discover they will owe a penalty in 2015 if they fail to secure coverage the opportunity to correct this problem and, if they are eligible, to get help paying for premiums and cost-sharing charges through the Exchange.

Other situations

There are many other situations where consumers may find themselves in a health plan which does not meet their needs due to a change *in the plan* – for example, due to a mid-year change in the plan’s provider network or coverage policies. While these are extremely serious problems, we believe HHS should address them through strict continuity of care requirements which hold plans accountable for any changes they make. For example, if a plan removes a consumer’s provider from their network mid-year, the plan should be required to allow the consumer to continue to see that provider on the same terms (e.g., without out-of-network cost-sharing or other penalties) until the start of enrollment after the next annual enrollment period. Such a policy protects consumers while placing the maximum incentive on plans to maintain consistent coverage. In contrast, providing an SEP in such circumstances would protect consumers but could potentially *reward* plans who want to rid themselves of consumers with certain medical conditions or types of providers, thus encouraging more (not less) mid-year changes.

§ 155.430 – Termination of Coverage

(b)(1) and (d)(2)(v)

We support provisions permitting consumers to terminate QHP coverage retroactively in circumstances where applicable state law authorizes “free look” or other trial enrollment periods. These provisions resolve potential conflicts with state laws, help protect consumers, and mitigate the harms of enrollment errors.

We support the removal of notice language in (b)(1), as the language is overly broad and the policy is also addressed in (d).

(b)(1)(iii)

We support the creation of a process to allow third parties to report the death of a consumer. We understand the need to have some mechanism to limit inappropriate use of this exception. We question whether allowing issuers to request documentation is the most effective method, as this may present an additional burden to third parties who are already grieving. Our recommendation would be a simpler requirement that the individual reporting the death be required to prove their own identity, thus ensuring an accountable party in the rare instances of fraud.

We also strongly suggest that HHS create an easy way to change the primary account holder on healthcare.gov. We have heard reports from consumers and assisters that if the primary account person dies that other individuals listed on the account have had great difficulties accessing the account (particularly at renewals), changing account information to reflect the death, and terminating the primary account holder’s coverage without impacting other family members. While we recognize this is not a regulatory issue, technological fixes must be implemented concurrent with regulatory provisions to ensure effective implementation of the regulatory framework.

Erroneous enrollment clarification

NHeLP suggests that HHS further amend § 155.430(b) to clarify that a QHP issuer may terminate coverage for an individual whom an Exchange has ultimately determined to be ineligible for enrollment. This clarification is important to ensure that consumers can be promptly enrolled in coverage during a special enrollment period (SEP) even if they have not yet provided all documentation of their eligibility. In a few states, QHP issuers have stated that they will not enroll applicants during a SEP unless the applicant has fully documented that she is eligible for a SEP. Issuers have justified this policy because they fear that the ACA's anti-rescission and anti-cancellation provisions might prohibit a plan from rescinding or cancelling a person's coverage if the person enrolls in a SEP after attesting to eligibility, but later evidence demonstrates that the person was not in fact eligible. It is in the interest of consumers to clarify that issuers can terminate such an ineligible enrollee, so that issuers will not require voluminous paper verification of SEP eligibility or delay enrollment until all elements of SEP eligibility are verified. Such verification and enrollment policies place enormous burdens on consumers, and will have the practical effect of delaying needed care even in cases where prompt care is particularly needed—such as immediately post-partum for new mothers and newborns. By clarifying that QHP issuers may terminate coverage if an Exchange determines that a person was erroneously enrolled in the QHP, HHS can help states to ensure that consumers are promptly enrolled in a QHP and able to receive needed care.

RECOMMENDATION: Amend § 155.430(b)(2)(i) as follows:

§ 155.430(b)(2)(i): The enrollee is no longer eligible for, ***or was never eligible for but was erroneously enrolled in,*** coverage in a QHP through the Exchange;

(d)(8)

We support the new language in (d)(8) ensuring appropriate actions are taken in all cases of retroactive terminations. We are concerned, however, that there is no SEP or SEP extension as the result of a “free look” cancelation. In particular, we are concerned that a consumer might be lured by the offer of a no-risk “free look”, only to find out afterward that ending the trial would result in no coverage at all. We recommend that HHS develop a way to ensure that consumers who make use of their state “free look” laws are not left without coverage options. We believe that a “free look” termination should be construed more like an involuntary termination which would trigger an SEP. If abuse of this policy is a concern, HHS could limit it's availability to two consecutive SEPs.

Guaranteed Availability and Renewability

Health plans may be available for purchase inside the Exchange (with APTCs and cost-sharing reductions) and in most cases outside the Exchange (without APTCs and cost-sharing reductions). Changes which make it impermissible for an individual to maintain coverage *inside* the Exchange (such as loss of “qualified individual” status) do not necessarily mean an individual should be terminated, because coverage *outside* of the Exchange may still be in effect for some individuals. We are therefore supportive of

HHS’s proposed regulatory approach regarding the term “termination of coverage,” which is to distinguish between circumstances that warrant termination of inside-Exchange enrollment status and circumstances warranting full termination of coverage. Full “termination of coverage” is too broad and potentially misapplied if used for situations only prohibiting purchase inside an Exchange.

General comments on Essential Health Benefits Package

NHeLP commends HHS for proposing new Essential Health Benefits (EHB) requirements that issuers must meet to satisfy the EHB. Below are general EHB comments followed by specific comments regarding the proposed rule.

Benchmarking Approach

NHeLP continues to oppose the use of a benchmarking approach to define the EHBs. There is a clear directive in the ACA requiring the Secretary of HHS to define the EHBs, and as a legal matter, HHS has no authority to delegate defining the EHBs to states or issuers. Clear federal minimum EHB standards are necessary to ensure that vulnerable populations can access comprehensive care that consistently meets their needs.

In comments to the EHB proposed rule (November 26, 2012), NHeLP recommended that HHS use the lessons learned in 2014 and 2015 to develop a unified national EHB standard. We continue to believe HHS must move towards compliance with the law and develop a strong federal standard. At this point, we know that realistically HHS may not have all 10 EHB categories defined in time for the 2016 plan year, so HHS should establish a minimum standard definition for 2-3 EHB benefit categories in time for 2016, and define the rest of the EHB categories by a set date. The federal definition should serve as a minimum standard that states can expand upon.

We commend HHS for proposing a uniform definition of habilitative services in this proposed rule (see our specific comments below). In the preamble, HHS indicates that the current habilitative services standard resulted in inadequate coverage of the benefit. This same issue applies to other EHB categories as well. One of those categories is pediatric services. Studies have shown that, to date, the process for defining EHBs has failed to ensure that pediatric services are adequately covered for children enrolled in individual and small group market plans.⁶ A robust and comprehensive EHB is critically important for children. Therefore we recommend that HHS establish a federal minimum definition for pediatric services based on either: 1) Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit standard, or 2) the Children’s Health Insurance Program (CHIP) coverage.

General Supplementing

⁶ [Comparison of Benefits and Cost Sharing in Children’s Health Insurance Programs to Qualified Health Plans](#), Wakely Consulting Group, July 2014.

While HHS continues to use the benchmarking approach to define EHBs, clearer “supplementing” guidelines are needed. Currently if a an EHB base-benchmark plan (BBP) selected by a state does not include items or services in one of the 10 EHB statutory categories, the BBP must be supplemented by adding that particular category in its entirety from any other EHB BBP option. But supplementing only occurs when the BBP does not cover *any* items or services in one of the ten EHB statutory categories. Therefore a plan with minimal coverage in one of the 10 categories does not get supplemented. We recommend that HHS create a minimum standard for coverage of each of the ten EHB statutory categories based on “adequate” coverage of that category. The Secretary should define “adequate” by reference to some objective criteria for each category based on the services needed to meet the needs of the covered populations. When a BBP does not have any services, and supplementation is required, the supplementation should also be required to meet the adequacy standard.

Substitution of Benefits

We urge HHS to eliminate any provision of issuer flexibility to substitute benefits. This authority undercuts the letter and intent of the ACA in a number of areas, including non-discrimination and meaningful coverage of the ten statutory categories. Currently issuers may substitute benefits that are actuarially equivalent to benefits replaced, as long as they are within the same benefit category (some exclusions apply). This means that issuers can substitute services that certain populations may need (e.g. individuals with chronic conditions) and replace them with services which are actuarially equivalent, and are less costly and likely to attract healthier populations. Also, since issuers are allowed to substitute benefits, consumers cannot make an adequate comparison of health coverage options, which makes plan selection difficult.

State Mandates

HHS must clarify the EHB state mandate policy for 2016 and beyond. For 2014 and 2015, state benefit mandates enacted on or before December 31st, 2011 (even if not effective until a later date) are not considered additional to the EHBs, so states do not have to defray the costs of covering these benefits. Due to this policy many individuals have continued to receive important health benefits. The policy has also minimized disruption and costs for states.

It is unclear what the EHB state mandates policy will be after 2015 and whether states will be responsible for the cost of mandates not included in the EHB BBP *that increase* the cost of premiums. Some states concerned with potential costs have passed new mandates but indicated the new mandates do not apply to plans required to provide the EHBs, to avoid any future cost issues. We urge HHS to clarify the state mandate policy for 2016 and beyond, and to create a process that allows new state-required benefits to be added to the EHB with no additional cost to the state. We recognize that HHS cannot allow states complete discretion to add mandates to the EHB standard given the state incentives and federal costs, but some public process should exist to add new mandates to the EHB, especially if they address important market coverage gaps and/or

help meet the health goals of the state. HHS should develop a controlled and limited process for states to demonstrate the significance of including new state-required benefits as EHB at no extra cost to the state.

EHB Updating Process

HHS must create a transparent and inclusive standardized process for developing, updating and reviewing EHBs, and set forth a framework for addressing barriers and gaps in access to care. Providing deference to states leaves significant issues undetermined.

RECOMMENDATIONS:

- *Benchmarking approach:* We recommend that HHS only use the benchmarking approach to define the EHBs on a transitional basis while working towards establishing a federal minimum definition for all 10 EHB statutory categories of benefits.
 - Given the timing, for plan year 2016, HHS should establish a minimum standard definition for 2-3 EHB benefit categories, and define the rest of the EHB categories by a set date. Two categories that require immediate attention are habilitative services and pediatric services.
- *General supplementing:* We recommend that HHS create a minimum standard for coverage of each of the ten EHB statutory categories based on “adequate” coverage of that category. The Secretary should define “adequate” by reference to some objective criteria for each category based on the services needed to meet the needs of the covered populations.
- *Substitution of benefits:* We urge HHS to eliminate any provision of issuer flexibility to substitute benefits.
- *State mandates:* We urge HHS to clarify the EHB state mandates policy for 2016 and beyond. HHS should also develop a controlled and limited process for states to demonstrate the significance of including new state-required benefits as EHB at no extra cost to the state.
- *EHB Updating Process:* We recommend that HHS create a transparent and inclusive standardized process for developing, updating and reviewing EHBs, and set forth a framework for addressing barriers and gaps in access to care.

Specific comments on Essential Health Benefits Package

§ 156.115 – Provision of EHB

§ 156.115(a)(5) Habilitative Services

We commend HHS for proposing to establish a uniform definition of habilitative services, and removing issuer flexibility to define the benefit. We agree with HHS that this will minimize: 1) variability in the benefit; and 2) lack of coverage of habilitative services versus rehabilitative services.

For individuals with disabilities and chronic conditions, habilitative services are vital health care services. Habilitative services help individuals (such as those with developmental disabilities or similar conditions) attain, improve, or maintain skills or functions they have not previously had. It differs from rehabilitative services, which help individuals regain a skill or function affected by illness, injury, or disabling condition. The types of services and devices used in habilitative and rehabilitative services are similar, but the purpose and use of the services are different.

The current habilitative services standard has resulted in inadequate coverage of the benefit. Setting parity with rehabilitative services as a standard is insufficient because these two benefits serve different purposes. Also, there is no certainty an adequate level of coverage in rehabilitative services exists in the first place. In addition, allowing issuer flexibility is not a valid implementation of the statutory requirement to cover these services. Therefore HHS should not maintain its current policy.

NHeLP supports a uniform definition of habilitative services. HHS' proposed definition offers a clear starting point. In addition, we recommend that any definition of habilitative services include a reference to habilitative "devices", which are a critical component of habilitative services. The ACA recognizes the importance of devices and includes both habilitative services and devices in its list of EHB categories. Further, we urge HHS to require that certain specified services and devices be included as habilitative services. These services, include, but are not limited to: physical, occupational, and speech-language pathology, audiology services, behavioral health services, durable medical equipment, orthotics, prosthetics, low vision aids, hearing aids, augmentative communication devices that aid in hearing and speech and other assistive technologies and supplies.

Even though HHS is proposing a federal definition, it appears states may continue to define habilitative services as long as they do so in a non-discriminatory manner. HHS proposes that the federal definition applies *only* if a state does not define the benefit. This means states that have defined the benefit inadequately can keep that definition instead of applying the federal minimum standard. We urge HHS to require all states to adopt the proposed uniform definition as a minimum standard unless the state's definition is more comprehensive. In addition, we urge HHS to require states to apply the federal definition even when the state's BBP includes coverage of *some* habilitative services. Currently, states define the benefit only when the base-benchmark plan does not include coverage of *any* habilitative services. We recommend that HHS clarify that either the federal definition of habilitative services or the state's definition (if more comprehensive) must be the minimum standard.

We applaud HHS for proposing several important consumer protections, and support all of them:

- removal of issuer flexibility to define habilitative services;

- separate limits for habilitative and rehabilitative services rather than retaining the rehabilitative services visit limit and having habilitative count toward the same visit limit; and
- no limits on coverage of habilitative services can be less favorable than any such limits imposed on coverage of rehabilitative services.

RECOMMENDATIONS:

- We recommend adding habilitative “devices” to the federal minimum definition of habilitative services.
- We urge HHS to require that certain specified services and devices be included as habilitative services. These services and devices, include but are not limited to: physical, occupational, and speech-language pathology, audiology services, behavioral health services, durable medical equipment, orthotics, prosthetics, low vision aids, hearing aids, augmentative communication devices that aid in hearing and speech and other assistive technologies and supplies.
- We urge HHS to require all states to adopt the proposed uniform definition as a minimum standard unless the state’s definition is more comprehensive. We urge HHS to clarify that either the federal definition of habilitative services or the state’s definition (if more comprehensive) must be the minimum standard.
- We urge HHS to require states to apply the federal definition even when the state’s BBP includes coverage of *some* habilitative services.

§ 156.115(a)(6) Pediatric Services

We commend HHS for proposing that EHB coverage for pediatric services should continue until the end of the plan year in which the enrollee turns 19 years of age. We agree with HHS that providing coverage until the end of the plan year in which a child turns 19 is best for continuity of care, but we believe this is not enough.

We encourage HHS to raise the age limit for pediatric services to age 21. The higher age limit aligns with existing standards for Medicaid and will ensure continuity of coverage for children transitioning between Exchange and Medicaid coverage.

RECOMMENDATION: We recommend amending § 156.115(a)(6) as follows:

§ 156.115(a)(6): For pediatric services that are required under § 156.110(a)(10), provide coverage for enrollees until **age 21**. ~~at least the end of the plan year in which the enrollee turns 19 years of age.~~

Collection of data to define essential health benefits (§ 156.120)

We commend HHS for collecting detailed information from states and issuers regarding new benchmark plans for 2017. HHS appears to propose that every state will either select a new BBP for the 2017 plan year or the default benchmark will apply. If a state selects a BBP that does not meet the EHB standards, the state will have to supplement

benefits to ensure coverage of all 10 EHB statutory categories. (*See our comments above regarding concerns with the general supplementing requirements.*)

In the preamble HHS seeks comment on alternate ways of addressing situations in which a state has few potential BBPs that meet the EHB standards from which to choose from. This is a good example of why clear federal minimum EHB standards are necessary, and why HHS must move towards compliance with the law and develop a strong federal standard.

§ 156.120(a) Definitions—Treatment Limitations

We commend HHS for collecting data on treatment limitations for the EHB BBPs. This data is important in order to fully understand a plan's benefit coverage. Information about treatment limitations can be difficult to find, even in a plan's Evidence of Coverage (EOC) therefore it is helpful to have this information. Beyond collecting this data for transparency purposes, HHS should evaluate the data and identify any treatment limitations that might be discriminatory. Given the Secretary's obligations under the ACA, this data should be used to ensure that arbitrary and unreasonable limits that restrict access to needed care not become part of the EHB. Also, the treatment limitations should include non-quantitative limits, such as prior authorization or step therapy requirements for prescription drugs, in addition to the quantitative limits already listed in the definition.

§ 156.120(b) Reporting requirement

HHS anticipates collection of new benchmark plan data for the 2017 plan year from states selecting a new BBP or issuers that offer a default benchmark plan. To clarify the list of benefits that states or issuers must provide to HHS, we recommend that "all health benefits in the plan" mean a list of all benefits in the plan's EOC. We believe this will help HHS collect a sufficient level of detail on the benefits covered rather than having states or issuers report broad categories of benefits. For example, in the California EHB Benchmark Plan summary currently posted on CCIIO's website, covered benefits such as "delivery and all inpatient services for maternity care" are not further described with specificity.⁷ Yet the EOC for California's BBP offers more detail on covered services within this category. Requiring issuers to report benefits to HHS as described in the plan's EOC will help enrollees, advocates, and stakeholders understand exactly what benefits are included in the BBP. States and issuers will also have clarity on how they are to report health benefits for their plan.

In addition, we recommend that HHS clarify that states and issuers must also provide information on any supplemental services that issuers are required to cover as part of the EHB requirement, including pediatric vision, pediatric oral, and habilitative services, as well as any state mandates that are part of the EHBs.

⁷ See <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/california-ehb-benchmark-plan.pdf>.

§ 156.122 – Prescription Drug Benefits

§ 156.122(a)

NHeLP applauds HHS for proposing to replace the current EHB standard for prescription drugs under United States Pharmacopeia (USP). The USP system was created for the Medicare Part D program and its beneficiaries, and therefore does not adequately classify and categorize drugs for individuals who do not meet Medicare eligibility standards. For example, some drugs consist of combination therapies that are not classified by the USP classification system and therefore may not be represented in EHB base-benchmark plans. Moreover, because the USP is only periodically updated, health plan enrollees may not have access to newly approved medications.

The proposed rule replaces the current USP standard with a requirement that health plans adopt a pharmacy and therapeutics (P&T) committee to ensure the plan's drug formularies cover a sufficient number and type of drugs. HHS also proposes using the American Hospital Formulary Service (AHFS) classification system either instead of, or in conjunction with, the P&T committee to establish, review, and update QHP drug formularies.

We agree that HHS should require health plans to use a combination of P&T committee recommendations and a recognized, comprehensive standard classification system when designing and updating their prescription drug formularies. The best way to ensure that enrollees have access to comprehensive prescription drug coverage is through a common organization and classification tool, as well as a committee process to review and update formularies based upon the most current standard of care and clinical practice guidelines. However, we lack sufficient information to specifically endorse AHFS as an improvement over USP. Moreover, we are concerned that AHFS is difficult to access and charges considerable fees for its drug classification system.

Quality, access, and coverage standards in publicly-funded health programs should be promulgated by public entities, not private companies. In addition, standards for prescription drug formularies should be publicly available, free of charge. Prohibitively expensive paywalls prevent consumers and other stakeholders from adequately assessing health plan formularies and their compliance with the ACA's EHB standards and non-discrimination provisions. We urge HHS to develop its own prescription drug classification standards and publications, rather than relying on those developed and published by private companies. In the interim, whatever standard classification system HHS employs (e.g., AHFS, USP, or something else) should be made available to consumers and other stakeholders without charge.

We agree that P&T committees can effectively complement a published drug classification system by providing a mechanism to expeditiously update prescription drug formularies. However, we urge HHS to institute P&T committees for plan year 2016 and not wait until 2017. Many health plans have experience operating P&T committees under Medicare Part D. However, we recommend that HHS adopt more

rigorous standards for P&T membership, conflict of interest, transparency, and opportunities for public participation.

We applaud HHS for requiring P&T committees to include practicing physicians and other health care professionals. For conditions such as HIV/AIDS, clinical advances are occurring so rapidly that clinicians who do not see patients may not be equipped to make judgments based on current practice standards. HHS should provide clear guidance to health plans that P&T committees must include a broad spectrum of providers and expertise.

We applaud HHS for requiring P&T committees to adhere to conflict of interest standards. However HHS should clarify conflict of interest disclosure, monitoring, and compliance requirements. In its 2013 review of Medicare P&T committees, the HHS Office of the Inspector General (OIG) identified numerous deficiencies in P&T conflicts of interest and made recommendations, including: (1) define pharmacy benefit managers as entities that could benefit from coverage decisions; (2) ensure that safeguards are in place to mitigate improprieties related to employment by the entity managing the P&T committee; (3) ensure that an objective process is used to determine conflicts; (4) ensure that an objective process is used to manage conflicts; and (5) oversee compliance with the requirement that a specified number of members be independent and free of conflict.⁸ We urge HHS to adopt these recommendations for QHP P&T committees.

Furthermore, the proposed rule allows the health plan P&T committees to develop a “reasonable definition” of conflict, and requires states to monitor and enforce P&T requirements. We disagree. HHS should develop, with stakeholder involvement, a “reasonable definition” of conflict of interest, and should develop additional standards and guidance for committees. Moreover, HHS should be primarily responsible for monitoring and enforcement activities by conducting compliance reviews, requiring corrective action plans if necessary, and by investigating consumer complaints.

In addition, HHS should require P&T committees to adhere to minimum transparency requirements, including holding public meetings, providing public notice of meeting times, posting the meeting agenda and minutes on the plan’s website so that they are readily and easily accessible for consumers and other stakeholders. Committee by-laws, membership, terms of appointment, and financial disclosure information should all be posted on the plans’ websites and be publicly available. HHS should also require committees to invite public comments. A 2006 review of P&T committees in Medicaid found that best practices include opportunities for stakeholder involvement, including public comment periods conducted in a manner that balances consumer needs with prompt decision making.⁹

⁸ See HHS OIG, *Gaps in Oversight of Conflicts of Interest in Medicare Prescription Drug Decisions*, 2013, available at: <https://oig.hhs.gov/oei/reports/oei-05-10-00450.pdf>.

⁹ See National Academy of State Health Policy, *State Experience in Creating Effective P&T Committees*, 2006, available at: <http://www.nashp.org/publication/state-experience-creating-effective-pt-committees>.

Finally, HHS should consider broadening the scope of P&T committees to include reviewing the appropriateness of medical management techniques such as prior authorization, pill quantity limits, and step therapy. For some conditions, such as HIV, step therapy requirements can endanger patient health and lead to avoidable opportunistic infections and drug resistance.

As we stated in our 2012 comments on the EHB regulations, HHS should include the Medicare Part D requirement to cover “all or substantially all” of the drugs in six protected classes of drugs which are critical to vulnerable populations. We note that these classes were explicitly included in Part D “because it was necessary to ensure that Medicare beneficiaries reliant upon these drugs would not be substantially discouraged from enrolling in certain Part D plans.”¹⁰ It would violate the nondiscrimination requirement for EHB coverage (see ACA § 1302(b)(4)) if this Medicare policy, specifically designed to prevent discrimination against certain populations, were not adopted in the EHB. For example, the current standard of care for treating HIV includes the simultaneous use of multiple antiretroviral medications that may be from the same drug class. The proposed rule would make meeting this standard of care impossible under some existing plan designs. We therefore urge HHS to supplement the proposed required drug benefit with the Medicare Part D “all or substantially all” standard for these classes.

Additionally, we ask HHS to reiterate that none of the potential limits on prescription drug coverage permitted under § 156.122 supersede the independent and enforceable EHB requirement found in § 156.115(a)(4), that a plan must cover all preventive services described in § 147.130, including all FDA-approved methods of contraception.

§ 156.122(c)

We commend HHS for requiring an exceptions process that would allow an enrollee to request appropriate drugs that are not covered by the health plan. Many individuals, such as those with complex medical interactions or allergies, will be unable to safely use medications that are on formulary. We ask for clarification from HHS on this exceptions process, including how it will ensure transparency and usability for all enrollees, including individuals with Limited English Proficiency (LEP).

We appreciate the timeframes in which a plan must act for an emergency health situation. We are also very supportive of the proposal to have such a standard exceptions process along with a secondary external review process. Adding both these measures will help patients access the medications prescribed for them by their provider. Finally, we are extremely pleased that HHS is clarifying that patient cost sharing for excepted drugs counts toward the maximum cost sharing limit.

We urge HHS to consider making this exceptions process broader than the prescription drug coverage category. With the significant insurer flexibility proposed in this rule, it is especially important that a consistent and easily navigated exceptions process exist for

¹⁰ Medicare Prescription Drug Benefit Manual Chapter 6 § 30.2.5.

accessing all services recommended by an individual's treating provider but not covered by the health plan. Cost-sharing for such clinically appropriate services and use of the exceptions process should not add any additional burden or barrier to this process.

In addition, HHS should monitor requests for expedited medication exceptions, as well as the timelines of decisions and outcomes. Inordinately high rates of expedited medication exceptions could indicate overly restrictive utilization management or drug formularies that are too limited to adequately meet enrollee's needs.

§ 156.122(d)

We strongly support HHS' proposal to increase formulary and provider transparency so that consumers can select the health plan that best meets their individual health care needs. Many 2015 plans still do not have a direct link to a plan's formulary on the "Summary of Benefits and Coverage" as required by the ACA. The proposed rule reiterates the ACA requirement that each plan publish up-to-date, complete formularies with tiering and any restrictions on accessing the drug. Formulary tiering information should include information on cost-sharing tiers and utilization controls, including prior authorization or step therapy requirements, for each drug covered by the product. Additionally, since plans increasingly use co-insurance, plans should provide a reasonable estimate of what the actual patient cost sharing will be in dollar terms. By not providing this information, patients are left in the dark when it comes to how much they will have to pay for a drug or service.

The list should indicate any drugs on the formulary that are preferred over other drugs on the formulary. Health plans should also include information to educate enrollees about the differences between drugs administered or provided under a health plan's medical benefit and drugs prescribed under a health plan's prescription drug benefit. Also, health plans should include information about how to obtain coverage information regarding drugs that are not covered under the plan's prescription drug benefit.

§ 156.122(e)

We applaud HHS' proposal that health plans can no longer offer the prescription drug benefit through mail order only. In the preamble, HHS recognizes that there are some circumstances where using mail order may be problematic (e.g., for persons do not want to disclose their medical condition to family members, or transient individuals with no fixed mailing address). However, HHS allows health plans to charge a higher cost-sharing amount when an enrollee uses an in-network brick-and-mortar pharmacy rather than mail order. This essentially penalizes individuals who may have no other choice but to use a brick-and-mortar pharmacy. We urge HHS to work with stakeholders to identify and implement an equitable solution to this problem. In the meantime, we urge that HHS implement the retail pharmacy requirement in 2016, rather than waiting until 2017. Additionally, we are concerned that the term "retail pharmacy" may not be broad enough to encompass other critical brick-and-mortar pharmacies such as in-network health clinics that dispense drugs onsite and urge HHS to issue clarifying guidance.

Finally, at the end of the preamble, HHS urges issuers to temporarily cover non-formulary drugs as if they were on the formulary during the first 30 days of coverage. We strongly support this proposal and urge HHS to make this policy "required" and not just "encouraged."

§ 156.125 – Prohibition on Discrimination

NHeLP applauds HHS for providing examples in the proposed rule's preamble of discriminatory practices by health plans and reminding plans of the ACA's non-discrimination requirements. HHS notes that prescription drug formularies that exclude preferred, commonly prescribed single tablet therapies, as well as formularies that place all drug used in the treatment for certain conditions in the highest cost sharing tier violate the ACA's non-discrimination requirements.

The ACA provides robust protections against long-standing discriminatory practices by health insurers. The ACA requires guaranteed issue of coverage in the individual and small group health insurance markets so that no one can be denied health insurance due to a preexisting condition. (42 U.S.C. § 300gg-1). The ACA prohibits discrimination against individual participants and beneficiaries based on health status or medical condition, and it prevents insurers from imposing annual or lifetime limits on benefits. (42 U.S.C. § 300gg-11).

The ACA contains additional protections for individuals by barring discriminatory plan benefit design, establishing that a QHP may "not employ marketing practices or benefit designs that **have the effect of discouraging the enrollment in such plan by individuals with significant health needs.**" (42 U.S.C. § 18031(c)(1)(a) (emphasis added); see also 45 C.F.R. §156.225(b)). A health plan fails to meet the essential health benefits standard if its benefit design discriminates based on an "individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions" and can be decertified from participation in the Exchange. (45 C.F.R. § 156.125(a)). ACA regulations further prohibit discrimination on the basis of on race, color, national origin, disability, age, sex, gender identity, or sexual orientation. (45 C.F.R. § 156.200(e)).

In addition, the ACA's Section 1557 applies several existing federal anti-discrimination and civil rights statutes, including the Rehabilitation Act, to the QHPs offered through the Exchanges. Section 1557 and the Rehabilitation Act prohibit discrimination on the basis of disability in federal programs, including the "contracts of insurance" available in the Exchanges.

However, despite these robust protections, some QHPs continue to discriminate against individuals with disabilities and those with serious or chronic medical conditions. NHeLP and The AIDS Institute filed a still-pending HIV/AIDS discrimination complaint with the HHS Office for Civil Rights (OCR) against four Florida QHPs that placed all HIV medications in the highest tier. Although two insurers signed a consent order with the Florida Office of Insurance Regulation, that order does not settle the OCR complaint, applies only to those insurers, and only for plan year 2015.

We note that a number of 2015 QHPs continue to place all HIV/AIDS medications in the highest cost sharing tier. These plans were approved to participate in the federally facilitated Exchange, despite the clear violation of the ACA's non-discrimination provisions as described by HHS in the preamble.

NHeLP strongly urges rigorous monitoring and enforcement of the ACA's non-discrimination provisions. We also urge clearer guidance and greater coordination among the several agencies responsible for enforcing these ACA protections, including OCR, CCIIO, CMS, the Department of Justice, as well state insurance regulators.

§ 156.130 – Cost-Sharing Requirements

§ 156.130(b) Non-calendar year plans

NHeLP commends HHS for proposing to add §156.130(b) to provide that non-calendar year plans that are subject to the annual limitation on cost-sharing must adhere to the limit for the entire plan year. With this clarification, non-calendar plans are not permitted to reset the annual limit on cost-sharing at the end of the calendar year when the end of the calendar year is not the end of the plan year. This requirement ensures the annual limitation consumer protection applies to individuals enrolled in non-calendar year plans as well.

§ 156.130(c) Special rule for network plans

NHeLP has serious concerns about HHS' proposal to allow plans to continue to exclude out-of-network cost-sharing towards a plan's annual out-of-pocket limits. HHS proposes to make a technical correction to clarify that issuers are not required to count the cost-sharing for out-of-network services toward the annual out-of-pocket limit. Providing issuers the option to include out-of-network cost-sharing towards the annual limit is an improvement over the current language, which seems to prohibit it, but it is not enough.

NHeLP recommends the regulation require issuers to include out-of-network cost-sharing in annual limit calculations. In the preamble to the EHB proposed rule (November 26, 2012), HHS acknowledged that out-of-network expenses need not factor into the actuarial value calculation because "only a small percentage of total costs come from out-of-network utilization" (77 Fed. Reg. 70655.) Since the total expenditures on such care are deemed low enough to disregard from the actuarial value calculation, including the out-of-network costs-sharing in the annual limits is the simplest policy administratively and should not have a significant cost impact.

If, however, HHS permits an exclusion for out-of-network cost-sharing, the language in the proposed regulation should establish an exceptions process for individuals who go out-of-network precisely due to insufficient in-network options. After a year of implementation, narrow networks and problems with inaccurate or out-of-date provider directories in the Exchanges have been widely documented. An individual should not be punished with higher cost-sharing due to the plan's inadequate network or the individual's special medical needs.

NHeLP therefore recommends that HHS include all out-of-network cost-sharing towards an individual's annual limit and deductible *unless* the issuer can document that it (1) was generally in compliance with the network adequacy requirement; and (2) that the enrollee had actually available in-network options. As part of this requirement, HHS must require that in-network options cannot be deemed "actually available" if the provider was not geographically accessible to the enrollee, was not accepting new patients, was unwilling or unable to provide the specific service needed by the enrollee, had an unreasonably long waiting time to see patients, or the Exchange has otherwise determined that the in-network option is not available or inappropriate, for example, due to a language access or physical access barrier. We propose specific measures of network adequacy in our comments to §156.230, below, which we recommend that HHS use also to determine when costs associated with out-of-network visits must count toward an enrollee's annual limit and deductible.

NHeLP also recommends that HHS develop related protections for copays and coinsurance. Specifically:

- Consumers meeting the criteria above for annual limits and deductibles (i.e., those with an inadequate network or no "actually available" provider) should always receive the plan's standard copay and coinsurance charges for its lowest cost-sharing tier.
- Consumers should have external appeal rights to review whether an in-network provider is actually accessible and available and appropriate for the consumer's needs.
- Consumers should be protected from surprise or unavoidable out-of-network bills, such as a scheduled non-emergency procedure at a participating in-network hospital where an undisclosed out-of-network provider provides a service, or bills for out-of-network emergency services.¹¹
- Consumers not meeting the above criteria could pay a higher copay or coinsurance, with a maximum allowable charge defined by HHS or the state. This would offer limited protection for consumers and allow them to plan for the added financial risk.

Protecting consumers who may need to go out-of-network is especially important to high need individuals who may require specialized care. For example, women with

¹¹ New York state recently passed legislation to "hold harmless" consumers from such surprise billing. See NY Senate Bill 6914, (March 31, 2014), Part H, http://assembly.state.ny.us/leg/?default_fld=&bn=S06914&term=2013&Summary=Y&Actions=Y&Text=Y&Votes=Y. This unfair practice has been widely documented. See Benjamin Lawsky, N. York Dept. of Financial Servs., *An Unwelcome Surprise*, (Mar. 7, 2012), <http://www.governor.ny.gov/assets/documents/DFS%20Report.pdf>. See also, Carrie Feibel, Nat. Pub. Radio, *Surprise Medical Bills: ER Is In Network, But Doctor Isn't*, (Nov. 11, 2014), <http://www.npr.org/blogs/health/2014/11/11/363059517/surprise-medical-bills-er-is-in-network-but-doctor-isnt>. California has similar protections in its managed care law. See CAL. HEALTH & SAFETY CODE § 1371.4(b); CAL. CODE REGS., tit. 28, § 1300.71(a)(3)(B); see also *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group*, 45 Cal.4th 497 (Cal. Sup. Ct. 2009).

difficult pregnancies sometimes cannot find adequate in-network high risk maternity care in a timely fashion.

Furthermore, we believe that notice to consumers about the potential cost of seeking out-of-network care is critical, will help to minimize unnecessary use of out-of-network services, and help to prevent excessive medical debt. HHS should require plans to inform members of the costs they may be charged for the out-of-network care. Also, HHS should ensure that plans require their network providers and facilities to disclose the cost and the use of non-network providers in advance of a member's decision to use out-of-network services.

Self-only coverage

We commend HHS for the clarification in the preamble that the annual limitation on cost-sharing for self-only coverage applies to all individuals regardless of whether the individual is covered by a self-only plan or by a plan other than self-only. This means the individual's cost-sharing for EHB services may not exceed the self-only annual limitation on cost-sharing. We recommend adding this language to the rule. We also believe that a simpler and fairer policy for HHS to consider would be to require plans to simply apply their self-only limits to all individuals with the other than self-only coverage. For example, an individual in family coverage in a \$5,000/\$10,000 split plan would have the individual's limit set at \$5,000 (and not another figure, such as \$6,850). In any case, HHS should further clarify that this protection also applies to the maximum allowable limits for individuals enrolled in cost-sharing reduction plans. That is, cost sharing for an individual enrolled in an other than self-only CSR plan in 2016 could not exceed \$2,250 for individuals with incomes 100-200% FPL, or \$5,450 for individuals with incomes 200-250% FPL.

Other cost-sharing comments:

NHeLP supports the proposed requirement that QHP issuers must provide a Summary of Benefits and Coverage (SBC) that accurately portrays the cost-sharing requirements for all silver plan variations with cost-sharing reductions applied. This ensures that individuals with lower incomes will have a clear picture of what their cost-sharing requirements will be prior to plan selection in 2016. We also support the requirement at §156.425 that QHPs provide notice (including an updated SBC) within 7 days for individuals whose eligibility for cost sharing reductions changes during the year.

§ 156.145 – Determination of minimum value

§ 156.145(a) Acceptable methods for determining MV

NHeLP applauds HHS for proposing to require employer-sponsored plans to meet the quantitative standard of the actuarial value of benefits, *and* provide a benefits package that offers a minimum standard of benefits to meet the minimum value requirement. This is an important step to close a loophole that allows some employers to evade employer responsibility penalties while offering inadequate "health coverage" to their employees. HHS specifically proposes that the benefits under employer-sponsored plans not subject to EHB must at least include *substantial* coverage of inpatient hospital

services and physician services to qualify as “minimum value.” While this is an important improvement over the current situation, which lacks any standard for benefits for large group and self-insured plans, we believe it is important to require coverage of other critical benefits as well.

We agree with HHS that the structure of the ACA supports the interpretation that the minimum value standard requires that employer-sponsored plans cover critical benefits. As indicated by HHS in the preamble, the minimum value requirement is intended to ensure that employer-sponsored plans (not otherwise subject to EHB requirements) at least satisfy basic standards for cost-sharing and benefit coverage. An employer-sponsored plan should not qualify as “minimum value” if it does not cover at least the most essential services and satisfy the actuarial value requirements. This is especially important because attaining the minimum value and affordability standards disqualifies employees (and possibly also their families) from premium tax credits in the Exchange, and also exempts an employer from potential penalties for not offering adequate coverage.

HHS justifiably claims that “substantial” inpatient hospital and physician services are fundamental to what can reasonably be called a “health plan.” Moreover, the data underlying the minimum value calculator is based on “typical” self-insured plans that almost universally included these two categories of services. Plans that do not include such basic benefits might attract a substantially different risk pool that would skew the results of the calculator. We note, however, that the minimum value standard population also excludes all plans that do not offer prescription drug coverage. By the same logic, an employer plan that does not offer prescription drug coverage might also produce skewed results with the minimum value calculator.

Therefore we agree that HHS should establish a “critical benefits” standard that applies to employer-sponsored plans. However, we believe this standard should compare more closely with the Essential Health Benefits and reflect all the most common elements of a typical self-insured plan—such as prescription drugs and emergency services—not just inpatient hospital and physician services. If HHS moves forward with only requiring employer-sponsored plans to provide *substantial* coverage of inpatient hospital services and physician services, HHS should define a minimum standard for “substantial coverage” for each category. It should also clarify where and how compliance with mental health parity law applies to this “critical benefits” standard.

Qualified Health Plan Minimum Certification Standards

§ 156.230 – Establishment of Exchange Network Adequacy Standards

We commend HHS for revisiting these regulations in light of the experience of the first year of QHP operation. Network adequacy protections are critical in making the promise of care in the Affordable Care Act real. NHeLP has written extensively about the importance of network adequacy for low-income consumers, in particular.¹² The

¹² See, e.g., NHeLP, NETWORK ADEQUACY LAWS IN COVERED CALIFORNIA PLANS (2014), available at <http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/network-adequacy-laws-in-covered->

consumer experience in QHPs in 2014 highlights a need for additional regulatory standards governing network adequacy. Consumers in the first open enrollment period struggled mightily to understand what providers would accept the QHP options available to them. Even after enrollment, many consumers were not able to find providers willing to provide them with needed care. And other consumers received large bills for services rendered that they believed their QHP would cover. These problems resulted in significant activity on network adequacy in multiple jurisdictions at multiple levels. As HHS mentions in the preamble to this proposed rule, the National Association of Insurance Commissioners (NAIC) initiated a revision of its model act on network adequacy this year, and we expect it will publish a revised model act in early 2015 (see 79 FR 70679). In the meantime, in response to concerns about network adequacy issues such as narrow networks, balance billing, and discontinuity of care, at least four states passed new network adequacy laws in 2014, and at least 12 states addressed network adequacy in regulation or other administrative guidance.

We appreciate HHS's attention to the NAIC process to amend its model act on network adequacy. Given the critical importance of access to benefits to consumers' health, however, we urge HHS not to delay on adopting stronger standards in this area. The NAIC model is unlikely to be final before mid-2015. Meanwhile, consumers are experiencing access problems now. As of December 19, 2014, we are aware of at least ten lawsuits filed in three states that contain allegations related to network inadequacies in QHPs. Some of these allegations reveal severe adequacy problems. For example, one New York case alleges that a QHP enrollee called more than 30 primary care doctors during September and October, 2014, but was unable to find a single one in his New York City ZIP code that accepted his QHP and was seeing new patients.¹³ More regulation in this area is sorely needed.

Because consumers urgently need stronger network adequacy protections, HHS should not wait for NAIC to issue model standards. NHeLP supports and participates in the work of the NAIC in designing a model act for health plan network adequacy, and commends HHS for looking to the NAIC model as a source of best practices. But ultimately, adoption of the NAIC's updated model act will be voluntary for any given state, and will depend on that state's priorities and politics. To ensure that all Exchange consumers nationwide are guaranteed access to appropriate, geographically accessible providers who can deliver medically necessary services, HHS must set a national floor for QHP networks by adopting specific network adequacy standards in regulation to uphold the statutory requirements for network adequacy under the Affordable Care Act. NAIC's work cannot supplant the role of HHS in ensuring that QHPs meet network adequacy standards. HHS should issue more detailed regulations in this area as soon as possible to protect consumers from plans that do not provide real access to the essential benefits.

[california-plans-issue-No-2](#); NHELP, MEDICAID MANAGED CARE MODEL PROVISIONS: NETWORK ADEQUACY (2014), available at <http://www.healthlaw.org/publications/browse-all-publications/medicaid-managed-Care-model-provisions-issue-3>; NHELP, NETWORK ADEQUACY IN MEDICAID MANAGED CARE: RECOMMENDATIONS FOR ADVOCATES (2013), available at <http://www.healthlaw.org/issues/medicaid/network-adequacy-in-medicare-managed-care>.

¹³ See Complaint at ¶¶ 16-124, *Fougner v. Empire Blue Cross*, No. 159791(N.Y. Sup. Ct. Oct. 6, 2014).

Strong HHS regulation of QHP networks is especially warranted since QHPs serve a comparatively vulnerable population. Unlike the NAIC model act, which could apply to a wide range of individual and group market plans serving the general public, HHS's network adequacy standards apply to individual market QHPs that serve a very high number of low-income individuals, women of child-bearing age, individuals with special health needs, and limited English proficient individuals. HHS estimates that 85 percent of QHP enrollees in 2014 received financial assistance.¹⁴ Moreover, QHPs enrolled nearly half a million children under age 18, and over 2 million adults aged 55 and older; these populations are likely to have special health care needs.¹⁵ QHPs in the FFM enrolled over 2 million women between the ages of 18 and 54.¹⁶ A recent report from California noted that almost 80 percent of those eligible to enroll in coverage through the state's Exchange did not speak English well.¹⁷

We emphasize that a network adequacy standard that only evaluates the numbers, types, and locations of providers may not be enough to ensure that enrollees have access to all covered services, since in most states, providers are not obligated to provide all covered services that fall within the scope of practice of their provider license. Enrollees may not be able to access needed care due to providers' protected refusal rights. For example, if a QHP only contracts with OB/GYNs who provide prenatal care, but refuse to provide counselling and prescriptions for family planning services, for example, enrollees will not have adequate access to those services. Enrollees may also not have adequate access due to lack of provider experience and expertise. For example, if a QHP contracts with several oncologists, but no oncologists with pediatric experience who can care for children with leukemia, enrollees do not have real access to the full scope of essential health benefits covered by the QHP. As described in greater detail below, we encourage HHS to work closely with states and issuers to ensure that enrollees have real access to the essential health benefits, including through out-of-network providers when no in-network provider is available to provide the needed service.

§ 156.230(a) – HHS should not limit network adequacy standards to closed-network plans.

In 2014, Exchanges offered plans with a variety of network-models, including HMOs, PPOs, EPOs, ACOs, POSs, and Tiered-HMOs. We appreciate that network adequacy may be measured differently in a closed-network, HMO-style plan, compared to an indemnity model plan. Nevertheless, significant variation exists among the various

¹⁴ DEPT. HEALTH & HUMAN SERVS., OFFICE OF THE ASST. SECT'Y FOR PLANNING AND EVALUATION, HEALTH INSURANCE MARKETPLACE: SUMMARY ENROLLMENT REPORT FOR THE INITIAL ANNUAL OPEN ENROLLMENT PERIOD 9 (2014).

¹⁵ *Id.* at 18.

¹⁶ *Id.* at 20.

¹⁷ JORDAN MEDINA & CARLA SAPORTA, COVERED CALIFORNIA'S FIRST YEAR: STRONG ENROLLMENT NUMBERS MASK SERIOUS GAPS 10 (2014), available at <http://greenlining.org/wp-content/uploads/2014/06/iHealth-Report-print-friendly.pdf>.

closed model plans. We recommend that HHS further define and clarify how this section applies to plans with various models.

For example, in 2014 QHP issuers in many states—including California, Missouri, New Jersey, New York, and Texas—offered Exclusive Provider Organization (“EPO”) model plans that combine the closed network model of an HMO with the flexibility to self-refer to specialists that is common in PPO model plans. EPOs are regulated differently depending on the state—for example, in Texas they fall under the state’s HMO laws, whereas in California, they are regulated under the state’s PPO laws. Because these EPO model plans provide little, if any, coverage for non-emergency services accessed from an out-of-network provider, they must offer adequate provider networks if enrollees are to access covered benefits. HHS should make clear that this section applies to EPO model plans.

In addition, in 2014 many QHP issuers offered plans with tiered networks, such as PPO model plans and tiered HMO model plans. In these plans, the QHP might cover physician services provided by “in-network” or “first tier” providers subject to a \$20 co-payment. But when these services are provided by an “out-of-network” or “second tier” provider, the QHP only pays 30 percent of the provider’s fee, which could require enrollees to pay hundreds of dollars for these services. In many cases, the enrollee’s share of the cost of care provided by out-of-network or higher tiered providers is not included in calculation of a plan’s actuarial value, and does not count toward the enrollee’s deductible or out-of-pocket maximum. For example, one California woman—Kathleen Moore—enrolled her family in a platinum, no deductible Blue Cross PPO-model plan that contracted with her cardiologist.¹⁸ After visiting her cardiologist in February, 2014, the plan informed Kathleen that her cardiologist was considered “out-of-network,” and billed her \$1,600 for the visit.¹⁹ Kathleen then learned that any bills she paid for her cardiology visits were not subject to an out-of-network deductible of \$10,000, and that only providers who were considered “in-network” would be covered without her first meeting a deductible.²⁰ Even when these nuances in plan design are adequately communicated to consumers, given the enormous cost of accessing out-of-network or higher tier providers in some of these plan models, HHS must ensure that the plan’s network or first tier provides enrollees with adequate access to out-of-network providers.

As far as we are aware, no QHP issuer offered a traditional health indemnity plan as a QHP option in any Exchange this year, and it is not clear that such a plan could meet QHP certification requirements. If any such models are certified to participate in future years, however, HHS must still take some measures to ensure that enrollees in the plan are able to find the providers they need. The ACA requires HHS to ensure that all QHPs provide adequate access to covered services.²¹ The ACA does not provide any exception from network adequacy for plans that do not rely on a closed network, nor

¹⁸ See *Complaint at ¶¶ 95-99, Felser et al. v. Blue Cross, No. BC550739*, (Cal. Sup. Ct., Jul. 8, 2014).

¹⁹ *Id.* at ¶¶ 99-102.

²⁰ *Id.* at ¶¶ 95-96, 102.

²¹ 42 U.S.C. § 18031(c)(1)(D)(i).

should HHS assume that health indemnity plans will provide sufficient access to care. HHS should amend this section to clarify that indemnity-model QHPs must also provide adequate provider networks.

RECOMMENDATION: We suggest amending § 155.230(a) to ensure that all QHPs, regardless of model, provide access to covered services through an adequate provider network:

- (a) General requirement. **A QHP that is a health indemnity plan shall demonstrate that it offers a sufficient choice of providers accepting its health plan able to ensure that all covered services will be accessible to enrollees without unreasonable delay.** Each QHP issuer that uses a provider network, **such as an HMO, PPO, POS, or EPO model plan,** must ensure that the provider network consisting of in-network providers **on the lowest cost tier,** as available to all enrollees, meets the following standards—

§ 156.230(a)(2) – HHS must set a national floor for network adequacy that measures access using specific, quantitative measures.

We commend HHS for using more detailed criteria to address network adequacy in the FFM through its 2015 letter to issuers. We especially appreciate that HHS has scrutinized FFM QHPs' provider networks more closely during the most recent QHP certification period, focusing on areas where consumers have historically experienced access problems, including hospital systems, mental health providers, oncology providers, and primary care providers. At this writing, we do not yet have the experience with the QHPs certified to participate in the FFM for 2015 coverage to know whether the "reasonable access" standard has been successful in ensuring access. We are concerned, however, that the letter to issuers does not contain any precise quantitative standards that would help insurance regulators, consumers, providers, and advocates to evaluate whether QHPs' networks comply with the standard. All stakeholders benefit when the standards are clear and easy to measure.

In addition, HHS's current network adequacy standard for the FFM is imprecise, and should be strengthened. We appreciate that HHS has taken its role in setting standards for and monitoring network adequacy in the FFM. HHS's letters to issuers for 2014 and 2015 have laid important groundwork to ensure that enrollees in FFM states have access to the essential health benefits. HHS has allowed state-based Exchanges wide latitude in setting their own network adequacy standards, however. While we support HHS's leaving the states with ample room to hold QHPs to higher standards, reflecting the particular needs of each state, we urge HHS to establish a national floor for network adequacy in these regulations. The ACA requires the Secretary of HHS to establish network adequacy requirements for issuers seeking certification of QHPs.²² The current approach to network adequacy standards has resulted in consumer protections varying widely across state lines. Many state-based Exchanges have also declined to directly

²² 42 U.S.C. § 18031(c)(1)(B).

regulate network adequacy, and have instead delegated this role to their Insurance Commissioners. The result is a confusing patchwork for consumers that has too often resulted in lack of access.

For these reasons, we urge HHS to adopt specific and measurable standards for network adequacy in all QHPs in the areas of geographic access, timely access, numbers and types of providers, out-of-network access and continuity of care, language access, and disability access, as explained in detail below.

HHS should require QHPs to demonstrate that their plans provide geographic access to services.

If a QHP's provider network only includes providers who are hundreds of miles away from its enrollees, it has not provided sufficient access to covered services. Thus, NHeLP recommends that HHS establish specific criteria to measure the maximum travel time and distance to providers. Such criteria are common in public programs such as Medicaid and TRICARE, and have also been adopted by many states. We suggest that HHS's criteria should explicitly account for variation in travel patterns, modes of transportation, and geography, including by requiring QHPs that serve communities along political borders to include in their networks providers located in neighboring counties and states, where appropriate considering existing patterns of care.

The standards suggested below, taken as a whole, will strike a balance between reasonable access and issuer flexibility. NHeLP recognizes, however, that there may be certain extremely underserved or sparsely populated areas that require alternative minimum standards for travel time and distance. NHeLP recommends that the Secretary require the Exchanges to develop criteria to evaluate when an alternative standard is truly warranted. The Secretary should also give the Exchanges guidance as to what alternative standards will be allowed; and require Secretary approval of any proposed alternative standards before they are implemented. Alternative standards should account for circumstances in which enrollees must be able to access services out-of-network as described in subsection d, above. In addition, QHPs that are unable to meet access standards should be encouraged to provide regular scheduled or as-needed transportation from areas within a designated area to network primary care providers, hospitals, and clinics, as necessary to ensure that such facilities remain reasonably accessible. Further, Exchanges should urge these QHPs to dispatch mobile health care vans to locations within the designated area at regular scheduled times, at least quarterly, or more frequently if medically necessary.

RECOMMENDATION: We suggest that HHS add the following language to § 156.230(a)(2):

(a)(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, ***including by ensuring:***

(A) Geographic access to care, considering the geography, travel patterns, and the means of transportation ordinarily used by QHP enrollees. Except as provide in subsection (v) below, the QHP issuer shall ensure that:

- (i) 90% of enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider.**
- (ii) 90% enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated hospital which has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services.**
- (iii) 90% enrollees have a residence or workplace within 60 minutes or 30 miles of a contracting or plan-operated laboratory, pharmacy and similar ancillary facilities that dispense services and goods by order or prescription on the primary care provider.**
- (iv) The QHP issuer shall account for existing patterns of care in its service area, and shall contract with providers in contingent areas, including out-of-state or out-of-county, as appropriate to meet the needs of enrollees.**
- (v) If a QHP demonstrates that it cannot meet the criteria described in section (2)(A), the Exchange shall determine alternative standards for the QHP. Alternative standards must be approved by the Secretary of HHS before they may be implemented. Alternative standards shall be approved when the QHP demonstrates that it cannot meet the criteria described in section (a)(5) above because additional travel is necessary due to the absence of providers (including providers not part of the network) in the area. Prior to approval, the QHP shall submit a detailed access plan that demonstrates that it will provide access to medically necessary services, using methods such as:
 - (I) Providing regular scheduled or as-needed transportation from areas within a designated area to network primary care providers, hospitals, and clinics, as necessary to ensure that such facilities remain reasonably accessible; or**
 - (II) Dispatching mobile health care vans to locations within the designated area at regular scheduled times, at least quarterly, or more frequently if medically necessary.****

HHS should require QHPs to demonstrate that their plans provide timely access to services.

NHeLP urges HHS to establish clear timely access standards for primary care, mental health, urgent care, specialty care, dental care, and ancillary care appointments.

Timeliness standards are crucial to ensuring that enrollees have access to all of the essential health benefits in a reasonable amount of time, by requiring plans to do more than merely show that they contract with a range of providers, but also by showing that those providers can actually provide needed care in a timely manner. These standards should also account for provider office hours, to ensure that services are available when enrollees need them. Timeliness standards are widely used by states and other regulators such as TRICARE to assess network adequacy. We urge HHS to require issuers to certify that participating QHPs meet specific quantitative standards for timely access. NHeLP recommends that HHS use the timely access standards developed by the California Department of Managed Health Care as a model for such standards, as set forth below.

RECOMMENDATION: We suggest that HHS add the following language to § 156.230(a)(2) immediately after the suggested section above:

(B): Timeliness of access to care and enrollee services. Each QHP issuer must demonstrate that its written standards ensure that its contracted provider network for each QHP has adequate capacity and availability of licensed health care providers to offer enrollees appointments as follows:

- (i) Urgent care appointments for medical or dental services shall be available within 48 hours of the request for appointment, except as provided in (vi);***
- (ii) Non-urgent appointments for primary and specialty care shall be available within 15 business days of the request for appointment, except as provided in (vi) and (vii);***
- (iii) Non-urgent appointments with a non-physician mental health care provider shall be available within 10 business days of the request for appointment, except as provided in (vi) and (vii);***
- (iv) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition shall be available within 15 business days of the request for appointment, except as provided in (vi) and (vii);***
- (v) Non-urgent dental appointments shall be offered within 30 business days of the request for appointment, except as provided in (vi); and***
- (vi) The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee;***
- (vii) The applicable waiting time for a particular appointment must be shortened if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as***

applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined that it is medically necessary for the enrollee to receive care more quickly; and

(viii) The network providers shall offer hours of operation that are convenient to the population served under the plan and do not discriminate against QHP enrollees.

(ix) Services included in the contract shall be available 24 hours a day, 7 days a week, when medically necessary.

HHS should require QHPs to demonstrate that their plans provide access to sufficient numbers and types of providers.

NHeLP recommends that HHS also establish specific criteria to measure the number of providers in a network. The goal of such criteria is ensuring that enrollees have meaningful access to the health care services they need. Thus, the metric for determining appropriate numbers of providers must account for the range of services offered by participating providers, and whether providers are accepting new patients. If an enrollee needs contraception, for example, but her plan only offers OB/GYNs who perform pelvic exams and provide prenatal care, the services she needs are not actually accessible to her. Similarly, if an enrollee needs primary care, but his plan does not offer any primary care providers who are accepting new patients, the services he needs are not actually accessible to him. For this reason, as described in greater detail below, we strongly support the proposed regulations governing essential community providers, and encourage HHS to ensure that QHPs contract with ECPs for the full range of services they offer, rather than only offering access to certain subsets of services.

HHS should annually develop criteria, to be published in guidance, to measure the number of providers that account for variation in specialty type and geography, similar to those used in the Medicare Advantage program. Each year HHS would review and update the criteria based on utilization patterns and clinical needs. Such criteria fulfill the goal of assuring that enrollees have access to services, while incorporating flexibility to account for local variation, and variation over time. NHeLP recommends that such criteria be developed using the 2013, 2014, and 2015 Medicare Advantage Network Adequacy Criteria as a model. In adapting this model for QHP issuers, HHS should consider the needs of the populations who will be purchasing health insurance through Exchanges, which are in some cases quite different than the Medicare population. QHPs enroll high numbers of children, people with disabilities, limited English proficient enrollees, and women of reproductive age.

We appreciate that, for 2015 in the FFM, HHS has paid particular attention to certain important provider types, including hospital systems, mental health providers, oncology providers, and primary care providers. In determining what provider types QHPs must account for, we urge HHS to focus on additional provider types that are needed by the Exchange population. In addition to the Essential Community Providers described

below, HHS should ensure that QHP networks include, in addition to the usual range of providers and facilities, access to the following providers, programs, and facilities: interpreters, inpatient and outpatient rehabilitative programs, providers of comprehensive rehabilitative and habilitative services, applied rehabilitative technology programs, wheelchair seating clinics (including access to wheelchair assessments), independent durable medical equipment providers, specialty care centers (including those Ryan White Care providers serving people living with HIV), providers of non-coercive reproductive health services, speech pathologists (including those experienced working with nonverbal individuals, persons with developmental disabilities, and persons who need speech generating devices), occupational therapists, orthotics providers and fabricators, physical therapists, case managers for those with significant non-medical barriers to care, and low vision centers.

RECOMMENDATION: We suggest that HHS add the following language to § 156.230(a)(2) immediately after the language cited above:

(C) Numbers and types of providers that meet or exceed the standards established by HHS, and that account for the services offered by networked providers, and the proportion of accepting new patients.

HHS should require QHPs to demonstrate that their plans provide reasonable access standards for out-of-network services

We urge HHS to establish specific standards under which QHP issuers would be required maintain a process to facilitate an enrollee's obtaining a covered benefit from an out-of-network provider at no additional cost if no network provider is available in a timely manner. Such a standard is vital to ensuring that enrollees have full access to covered health care services. For example, the incidence of high-risk pregnancies is increasing in the U.S. Women with high-risk pregnancies may need access to specialized services that are not available in the network. Similarly, the ACA contemplates that QHPs may cover abortion services. These services may also not be available from providers in the network, especially for women in medically fragile and/or emergent conditions who may need access to hospital-based abortion care. NHeLP suggests that HHS establish a standard that would require QHP issuers to maintain a process and criteria for timely evaluation of access to out-of-network providers to obtain covered services without penalty or additional cost to the patient. As described in our comments to subsection (a), above, this requirement must include protections against additional cost-sharing in plans that have an out-of-network benefit or a tiered network, if needed services are not available in the lowest cost-sharing network or tier.

In addition, HHS should explicitly require plans to provide access to out-of-network providers in certain circumstances to ensure continuity of care. In 2014, many new Exchange enrollees experienced gaps in care when their providers were not included in their new QHPs. This problem can be ameliorated in part through more stringent regulation of provider directories aimed at ensuring that consumers know which QHP

options contract with their providers, as described above. But even when consumers have complete and up-to-date information, they may not be able to choose a QHP that contracts with their preferred providers. In 2014, consumers with disabilities and chronic conditions who have close relationships with multiple providers often were not able to find one plan that contracted with all of their providers, and many experienced gaps in care as a result. For enrollees who are actively receiving care for an ongoing condition, these gaps in care can have enormous consequences for health. In addition, because consumers must choose a plan for an entire year, but QHPs can change their provider contracts at any time (as long as requisite notice is given), these continuity gaps are not limited to the initial enrollment period, but can occur at various times throughout the year.

For example, our California office assisted a woman who is being treated for breast cancer, and started a nine-month treatment regimen following a lumpectomy in July, 2014. Her QHP informed her in October 2014 that it would no longer offer a product that covers her oncologist and her surgeon in 2015; she researched her other plan options for 2015 but none of her other choices will cover her providers, either. Her treatment will be at a crucial stage in January, and changing providers could have hugely adverse consequences on her health. But currently she does not have any guarantee that she will be able to continue treatment with her providers. Similar examples are potentially a problem for numerous other consumers, such as women who may be forced to switch OBs or midwives within weeks of giving birth, and individuals who are facing terminal illnesses who may have to switch hospice providers.

We appreciate the language in the preamble to this regulation that exhorts QHPs to provide new enrollees with 30 days of transition coverage with their current providers when those providers are not contracted with the QHP. 79 FR 70726. We urge HHS to codify this requirement in the regulation to make such transition coverage mandatory for QHPs. We also suggest that HHS extend the length of the transition period to 90 days, and longer, as appropriate for enrollees who are completing covered services or treatment, pregnant, or receiving care for a terminal illness. HHS should require QHPs to cover ongoing treatment for the duration of the treatment from out-of-network providers for enrollees who are in an active course of treatment; to cover needed prenatal care, labor and delivery, and postpartum care from an out-of-network provider; and to cover treatment for terminal illnesses provided by out-of-network providers for until the enrollee's death. HHS should clarify that these protections should be offered to new enrollees upon enrollment, and for enrollees with providers who were originally in the QHP's network, but with whom the QHP terminates its contract, assuming the termination is not for cause.

RECOMMENDATION: We suggest that HHS add the following language to § 156.230(a)(2) immediately after the language cited above:

(D): Timely and adequate access to services at no additional cost from out-of-network providers when—

- (i) The service or type of provider (including training, experience, specialization, and linguistic and cultural competency) is not available within the QHPs network in the lowest cost-sharing tier;**
- (ii) The only plan or provider available to the enrollee in the lowest cost-sharing tier does not, because of moral or religious objections, provide the service the enrollee seeks;**
- (iii) The enrollee's primary care provider or other provider determines that the enrollee needs related services that would subject the enrollee to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network in the lowest cost-sharing tier;**
- (iv) The enrollee is completing covered services or treatment that: either the enrollee was receiving from a provider who is not included in the QHP's lowest cost-sharing tier at the time of enrollment into the QHP, or that the enrollee was receiving from a provider who was previously included in the QHP's lowest cost-sharing tier, but with whom the QHP subsequently terminates its contract, or moves to a higher cost-sharing tier, as follows:**
 - (I) For enrollees who are pregnant, the QHP issuer shall provide access to out-of-network providers providing prenatal care, labor and delivery services, and post-partum care for the duration of the pregnancy and post-partum period;**
 - (II) For enrollees who are receiving care for a terminal illness, the QHP issuer shall provide access to out-of-network providers providing treatment or hospice services for the illness for the duration of that illness;**
 - (III) For all other continuing covered services or treatments, the QHP issuer shall provide access to out-of-network providers providing the covered service or treatment for a minimum of 90 days;**
 - (IV) An enrollee shall be entitled to complete covered services or treatment with an out-of-network provider as described in this subsection as long as—**
 - (a) The QHP issuer determines that the enrollee has seen the provider at least once in the 12 month period immediately preceding the enrollee's request for continuity of care;**
 - (b) The provider is willing to accept the higher of contract rates of the QHP, or the applicable Medicare rate; and**
 - (c) The provider meets the applicable professional quality standards of the QHP.**
- (v) The Exchange determines that other circumstances warrant out-of-network treatment.**
- (vi) The enrollee seeks care from an in-network provider, but is treated by an out-of-network provider in the course of treatment.**

HHS should require QHPs to demonstrate that their plans provide language access to limited English-proficient enrollees.

HHS must adopt standards that account for the capacity of providers to serve limited English proficient (LEP) individuals. Large numbers of LEP individuals are purchasing insurance through the Exchanges and HHS must ensure that those QHPs offer linguistically appropriate supports. While Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act apply to QHPs, we believe HHS should adopt more explicit standards to ensure effective language services are actually provided. At a minimum, HHS should require all QHP issuers to identify the linguistic needs of enrollees and provide free language assistance services at all points of contact. For example, this requirement currently applies to plans in California.²³ NHeLP encourages HHS to adopt additional standards to ensure that LEP enrollees have meaningful access to care, by adopting stronger standards to ensure that enrollees have access to oral interpretation, and by requiring plans to report on bilingual providers (discussed in the section on provider directories, below).

HHS should explicitly require plans pay for interpretation services for their contracted providers. We urge HHS to require QHP issuers to arrange in their provider contracts to pay for interpreters directly, even in interactions between provider and patient, to ensure the availability of language services and improve compliance by providers who often do not have the resources to evaluate or pay for competent language services. Before any Exchange certifies a plan for participation, HHS should ensure that the Exchange requires the plan to set forth in detail its process for paying for and guaranteeing timely oral interpretation services, both for its own customer service functions and whenever necessary to facilitate communication between enrollees and providers. These language access policies should be made available to the public on each Exchange's website.

RECOMMENDATION: We suggest that HHS add the following language to § 156.230(a)(2) immediately after the language cited above:

(E) Timely and adequate access to language-appropriate services at no additional cost to the enrollee. QHP issuers shall assess the linguistic capacity of enrollees and shall provide free language assistance at all points of contact. QHP issuers shall also have a written policy to ensure that enrollees' language access needs are met, which shall provide for the issuers' direct payment of interpreter services; this policy shall be made available to the public on each Exchange's website.

HHS should require QHPs to demonstrate that their plans provide physical and programmatic access to services for enrollees with disabilities.

²³ See Cal. Code Regs., tit. 28 § 1300.67.04(c).

Finally, HHS should adopt standards that ensure that enrollees with disabilities have full access to needed care. These standards must account for the accommodations that may be needed by people with developmental or mental disabilities. Finally, HHS should require QHPs and their providers to certify that their facilities and services are accessible to all enrollees, and fully compliant with the Americans with Disabilities Act (ADA) and other state and federal disability and civil rights laws.

RECOMMENDATION: We suggest that HHS add the following language to § 156.230(a)(2) immediately after the language cited above:

(F) Physically and programmatically accessible services for enrollees with disabilities. QHP issuers shall establish written standards for their providers that ensure that provider facilities are accessible to people with disabilities and compliant with the Americans with Disabilities Act and any other applicable state and federal laws.

§ 156.230(a)(2) – HHS should implement additional monitoring requirements to ensure that network adequacy requirements are enforced.

Continual monitoring and enforcement of QHP networks is as important as review during the initial certification period. Because provider contracts can be added, amended, or dropped throughout the plan year, there is the strong possibility that issuers will submit robust network plans without maintaining networks throughout the year. This could cause serious access gaps and disrupt continuity of care issues for enrollees, who may be unable to change plans outside of open enrollment periods. We urge HHS to require QHPs to comply with monitoring and enforcement policies that ensure adequate oversight of QHP networks' compliance with network adequacy standards throughout the coverage year. While the recertification process will give the Exchanges an opportunity to review QHPs compliance with its network adequacy criteria, we urge HHS to require Exchanges to work with their QHPs to monitor compliance more frequently. We ask HHS to codify specific network monitoring requirements in the areas of geo-access mapping, timely access reporting, material network change reporting, secret shopper surveys, internal and external appeals, corrective actions by Exchanges, as explained in greater detail below.

Further, any monitoring process used by QHPs and Exchanges must be transparent, publicly available, and easy for consumers to understand. Information derived through the monitoring process must be broadly disseminated and accessible online and in written form. And, like all information provided in connection with the Exchanges, this information should be conveyed in a manner that is easily understood and accessible to people with low literacy, limited English proficiency, and disabilities.

RECOMMENDATION: We suggest that HHS add the following language to § 156.230(a)(2) immediately after the language cited above:

(G) Each QHP issuer shall give assurances to the Exchange and provide—at least annually—supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State's standards for access to care and the standards set forth in subsections (A) through (F) above. Each QHP issuer shall post on the Exchange's website an annual report that compiles and summarizes all of the information contained in the documentation it reports to the Exchange, and shall also make such reporting available in hard copy formats. The summary shall be accessible to people with low literacy, limited English proficiency, and disabilities. The summary must allow consumers to compare the performance of plans and their contracting providers in complying with the applicable standards, as well as changes in the compliance of plans with these standards. The annual documentation reported by QHP issuers shall include:

HHS should require QHPs to regularly provide geo-access maps of their networks to the Exchange

The best way to evaluate whether a QHP's network provides geographic access to care is to map the locations of the contracted providers relative to the homes and workplaces of enrollees and potential enrollees. We strongly recommend that HHS require QHPs to submit such mapping to the Exchanges at least once per year. HHS should look to California's geo-mapping requirements as a model for these requirements.²⁴

RECOMMENDATION: We suggest that HHS add the following language to § 156.230(a)(2) immediately after the language cited above:

(G)(i) A map or maps upon which the information specified below is indicated by the specified system of symbols. The map(s) employed should be of convenient size and of the largest scale sufficient to include the applicant's entire service area and the surrounding area in which the actual or projected enrollees live or work. The use of good-quality city street maps or the street and highway maps available for various metropolitan areas, and regions of the State, such as are commonly available from automobile associations or retail service stations or from an internet or computer based program is preferred. The map or maps should show the following information:

- (I) Such geographic detail, including highways and major streets, as is generally portrayed on the kinds of maps referred to above.**
- (II) The boundaries of applicant's service area.**
- (III) The location of any contracting or plan-operated hospital and, if separate, each contracting or plan operated emergency health**

²⁴ See CAL. CODE REGS., tit. 28, § § 1300.51.

- care facility. Hospitals are to be designated by an “H” and emergency care facilities by an “E.”*
- (IV) The location of primary care providers, designated by a “P.” For convenience, the primary care providers within any mile-square area may be considered as being at one location within that area.*
 - (V) The location of all other contracting or plan-operated health care providers including the following: Dental, designated by a “D.” Pharmacy, designated by an “Rx.” Laboratory, designated by an “L.” Eye Care, designated by an “O.” Specialists and ancillary health care providers, designated by an “S.” Providers of home and community-based long term services and supports, designated by “HCB.”*
 - (VI) The location of all subscriber groups which have submitted letters of intent or interest to join the applicant's plan designated by a “G.”*
 - (VII) Each QHP shall attach an index to the map or maps described in subsection (i) which shows, for each symbol placed on the map for a hospital, emergency care facility, primary care provider or ancillary provider, the following information:
 - (a) For each hospital, its total beds and the number of beds available to enrollees of the plan.*
 - (b) For each symbol for primary care providers, the number of full-time equivalent primary care providers represented by that symbol.**
- (3) For each interested subscriber group, the name of the group and the projected number of enrollees from that group.*

HHS should ensure that Exchanges periodically review QHPs’ timely access reports

HHS should also require Exchanges to collect annual reports from QHP issuers that document their compliance with timely access standards. We recommend that HHS work with the Exchanges to develop a standardized reporting template to collect compliance information in a uniform way, so that consumers can easily digest and compare plans’ performance with respect to timely access.

RECOMMENDATION: We suggest that HHS add the following language to § 156.230(a)(2)(G) immediately after the language cited above:

- (G)(ii) A report on the QHP issuer’s compliance with the timely access standards set forth in subsection (B) above and any applicable state standards in a manner using a standardized methodology for reporting developed by the Exchange in consultation with HHS. The methodologies shall be sufficient to determine compliance with the standards developed under this section for different networks of***

providers if a health care service plan uses different networks for product lines.

HHS should ensure that QHP issuers regularly review internal and external appeals to identify potential network problems and report their findings

NHeLP also recommends that HHS require QHP issuers to regularly review all internal and external appeals, complaints, and grievances related to access to care. QHP issuers must identify trends and report their findings to the Exchange. HHS should encourage Exchanges to perform their own, independent reviews or audits of appeals, complaints, and grievances for each QHP issuer to validate its finding.

RECOMMENDATION: We suggest that HHS add the following language to § 156.230(a)(2)(G) immediately after the language cited above:

(G)(iii): A report detailing the number of internal and external appeals, complaints, and grievances regarding network adequacy and timely access that the QHP issuer received during the preceding calendar year, that tallies the proportion of such cases that were resolved in the enrollee's favor, identifies any trends, and specifies corrective actions taken to resolve any problems identified by the issuer.

HHS should affirm that Exchanges may require QHPs to take corrective action when it finds their networks inadequate

Finally, we ask HHS to clarify that Exchanges may require issuers to take corrective action—including broadening QHP networks—to address network adequacy concerns during the coverage year to ensure enrollees have adequate access to covered health services.

RECOMMENDATION: We suggest that HHS add the following language to § 156.230(a)(2) immediately after the language cited above:

(H): The Exchange may take corrective action to address any network deficiencies during the plan year when necessary to ensure that enrollees have adequate access to covered services.

§ 156.230(b) – HHS should strengthen QHP issuers' duty to provide accurate and up-to-date provider directories.

We support the amendments to this section aimed at ensuring that consumers have more accurate information about what providers contract with their QHPs prior to enrollment. As HHS is well aware, consumers were plagued by inaccurate and unavailable provider directories during the first open enrollment period and throughout 2014. Numerous lawsuits—many of them class actions—have been filed against QHP issuers related to incomplete, inaccurate, and/or misleading information contained in

their provider directories. In addition, at least three states have taken administrative actions against QHP issuers to address provider directory problems. These proposed regulations make tremendous strides toward ensuring that enrollees and potential enrollees will be able to access the information they need about QHP provider networks.

We particularly commend the proposed language at § 156.230(b)(1) that would require QHP issuers to ensure that their directories allow “[t]he general public is able to view all of the current providers for a plan in the provider directory on the issuer’s public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number.” This year, too often, finding a provider directory required consumers to click through multiple layers of the issuer’s website, or create an online account. We also appreciate that the proposed rule would take important steps to ensure that provider directories are truly available and accessible to consumers.

Given that most plans do update their directories frequently based on the information they receive from providers, but very severe provider directory inaccuracies persist, NHeLP strongly believes that additional measures must be in place to address this problem. Inaccurate directories mask issues of inadequate networks and make it impossible for consumers to identify plans that meet their needs when shopping and find providers when it is time for them to obtain care. While standards that require plans to conduct timely directory updates are important for directory accuracy, they simply are not sufficient. If providers retire, move away, or die and never intend or are unable to notify a carrier of their network status change, such standards will not lead to accurate directories. Although it is often the contractual obligation of providers and facilities to inform carriers when their practicing status or contact information changes, the reality is that relying on such measures alone has not led to accurate directories. Thus HHS must implement more effective standards to ensure that these consumer rights are fulfilled. NHeLP’s recommendations aimed at further strengthening this section are set forth in detail below.

§ 156.230(b)(1) – HHS should require issuers to provide their directories in a format or template that facilitates comparison.

Consumers will benefit from being able to easily compare QHP’s provider networks. To this end, we support the preamble language suggesting that the final regulation should require QHPs to provide their directories in a machine-readable format for easy aggregation.²⁵ We would also support the alternative proposed in the preamble: a requirement that QHPs submit their directories to HHS using a template.²⁶ We believe this would be beneficial for creating different ways that consumers could access provider information, and hopefully could also catalyze increased accuracy of provider directories as more entities review directory information and make it publicly accessible. We also support the submission of this type of information directly to HHS and hope that HHS can eventually create integrated provider directories for the FFM. Integrated,

²⁵ 79 FR 70726.

²⁶ *Id.*

searchable directories could potentially be more accurate than existing directories if they allowed integrated updates. For example, if a provider retired, the provider could inform the Exchange or Exchange directory manager that he or she was no longer practicing, and the provider could be removed from all plans' directories simultaneously, instead of having to communicate with multiple issuers' and wait for each of those issuers to remove the provider's information from their directories.

§ 156.230(b)(2) – HHS should require issuers to update their provider directories at least once every 15 days.

NHeLP strongly supports the proposed language in subsection (b)(2) that will require QHP issuers to “publish an up-to-date . . . provider directory.” We appreciate the preamble language that would mandate issuers to update their directories at least once per month.²⁷ It is our understanding that most plans already update their directories based on information they receive from health care providers much more frequently than this, such as weekly or even daily. Therefore, we recommend shortening this timeframe to every 15 days, which is the time frame required currently in New York, and codifying it in the regulation.

RECOMMENDATION: We suggest that HHS amend this section as follows:

§ 156.230(b)(2): A QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM. ***The QHP issuer must update the directory information at least once every 15 days.*** A provider directory is easily accessible when—

§ 156.230(b)(2) – HHS should require issuers to include more information in their directories.

NHeLP commends the proposed language in subsection (b)(2) that will require QHP issuers to “publish an . . . accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations. . . .” This robust requirement will help to ensure that consumers know whether their current providers are included in their QHP choices, and also to find new providers when needed. In addition to the information listed in the proposed rule, we encourage HHS to require QHP issuers to include specific descriptions of any available telemedicine and transportation services they offer.

HHS should also require QHP issuers to include information about the physical accessibility of provider offices and facilities for people with disabilities, to ensure that consumers can really find a provider that meets their needs. This information should

²⁷ *Id.*

encompass an explanation of what interpreter services or communication and language assistance services are available at contracted providers and facilities, and should include information about how enrollees can obtain such services.

Further, HHS should ensure that the QHP issuers' directories inform potential enrollees of the languages spoken by network providers as a condition of certification. It is critical, however, that any provider or staff member who identifies as speaking another language be competent to do so. We encourage HHS to require the Exchanges to ensure that QHPs assess the language proficiency of their contracted providers, and the providers' staff, who seek to provide services directly in a non-English language. Otherwise, enrollees may suffer ineffective communication that can result in serious medical harm due to a lack of language proficiency, particularly with regards to the specialized medical terminology that someone who is conversationally bilingual may not possess. For example, in a study commissioned by NHeLP examining language barriers and medical malpractice, 32 of 35 claims involving language issues arose from providers failing to use competent interpreters.²⁸ We recommend that HHS work with the Exchanges to implement specific competency standards for all those who seek to provide services directly in a non-English language or serve as interpreters and limit those who may list language skills in a provider directory to providers who have established competency.

§ 156.230(b)(2) – HHS should ensure that provider directories clearly explain in versus out-of-network options and cost-sharing tiers to inform consumer choice.

We strongly support the proposed requirement at §156.230(b)(2) that when issuers offer QHPs with different provider networks, the directory be designed in a way that allows the “general public is able to easily discern which providers participate in which plans and which provider networks.” This commonsense rule will ensure that consumers can evaluate their provider options for all of the choices with which they are presented. We suggest that HHS further amend this section to require PPO-model plans and plans with tiered networks to also design their directories to make any distinctions in network that have cost-sharing implications for enrollees very clear. This information is crucially important for the relatively low-income population served by the Exchanges, who must be able to make choices based on accurate assumptions about their potential cost-sharing liability.

§ 156.230(b) – HHS should amend this section to require that all directories include a reporting mechanism for inaccurate listings.

We suggest that HHS amend this section to require issuers to establish an email address or phone number through which the public may directly notify the plan when provider directory information is inaccurate, and to prominently display this information in their directories. This email address or other channel for submission should be used

²⁸ NHELP, THE HIGH COSTS OF LANGUAGE BARRIERS IN MEDICAL MALPRACTICE (2010), *available at* http://www.healthlaw.org/images/stories/High_Costs_of_Language_Barriers_in_Malpractice.pdf.

for no other purpose but collecting inaccurate provider directory information. HHS should also hold issuers accountable for investigating these reports and modifying their directories in accordance with the findings of the investigations within 7 business days of receiving reports of inaccuracies. We recommend that HHS require issuers to report annually to the Exchange on the number of reports received, the timeliness of the plans' response, and the corrective actions taken; these reports should be publicly posted on the Exchange website and accessible to LEP individuals and those with disabilities.

§ 156.230(b) – HHS should amend this section to require issuers to regularly audit their directory listings.

We recommend that HHS require plans to regularly audit their directories and modify directories accordingly based on audit findings. HHS should require issuers to call at least 30 percent of providers in each specialty in their directory twice a year (or for specialties in which 30 or fewer providers or facilities are listed, to call all providers and facilities in the specialty) to assess: 1) whether their contact information is correct; 2) whether they are really in the plan's network; and 3) whether they are taking new patients. If any of the information listed in the directory is found to be inaccurate based on the findings of the audit, the issuer must update the directory within 15 days of the date in which the specific inaccuracy is noted. HHS should encourage issuers and Exchanges to also perform periodic "secret shopper" surveys of provider listings in order to assess the accuracy of directory listings from a consumer's point of view.²⁹

§ 156.230(b) – HHS should require issuers to contact providers who have not submitted claims within the past six months.

To further ensure that information in provider directories is accurate, we suggest that HHS require issuers to reach out to providers who are listed as in network who have not submitted claims within the past six months to determine whether the provider still intends to be in network. Based on the provider's response, HHS should require the issuer to update the directory accordingly. If the provider does not respond within 30 days, HHS should require the issuer to attempt contact again, and if the provider does not respond within another 30 days, the issuer must remove the provider's information from the directory. (This recommendation is based on a similar requirement under NJ regulation, N.J.A.C. 11:24C-4.6.)

§ 156.230(b) – HHS should require issuers to honor provider directory information.

If a consumer relies on materially inaccurate information from a directory indicating that a provider is in-network and receives care from that provider, HHS should require issuers to ensure that the consumer is held harmless. In these cases, HHS should

²⁹ California's Department of Managed Health Care recently used this methodology to audit two QHPs in Covered California after reports of serious inaccuracies in their directories. See CAL. DEPT. OF MANAGED HEALTH CARE, FINAL REPORT: NON-ROUTINE SURVEY OF BLUE SHIELD OF CALIFORNIA (2014), available at <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/043fsnr111814.pdf>; CAL. DEPT. OF MANAGED HEALTH CARE, FINAL REPORT: NON-ROUTINE SURVEY OF ANTHEM BLUE CROSS (2014), available at <http://www.dmhc.ca.gov/desktopmodules/dmhc/medsurveys/surveys/303fsnr111814.pdf>.

require the issuer to pay the provider an in-network rate and charge the consumer only in-network cost-sharing for the care.

§ 156.235 – Essential Community Providers

NHeLP commends HHS’s efforts to strengthen the Essential Community Provider (ECP) standard and address concerns safety-net providers have raised. This section codifies the ACA requirement that QHP networks must contract with ECPs who provide care to predominately low-income and medically-underserved populations, in order to be certified as QHPs. The Health Resources and Services Administration (HRSA) defines medically-underserved populations, as “having too few primary care providers, high infant mortality, high poverty, and/or high elderly population.”³⁰ Moreover, § 1311 of the ACA also indicates that the functions of the Exchanges should be to improve health outcomes and implement activities that reduce health and health care disparities. Since QHPs serve large numbers of women of childbearing age, it is also crucially important that HHS ensures that their networks include ECPs that can serve the unique health needs of women. We are pleased by the strides this proposed rule makes toward ensuring participation by the full range of ECPs that currently comprise the safety-net of providers who provide health care to low-income communities. We believe that the approach taken by this proposal makes inclusion of ECPs in QHP networks straightforward for consumers, providers, and issuers. We also encourage HHS to take steps to further strengthen the rule to ensure that consumers have robust access to the providers and health care they need to stay healthy, as described in greater detail below.

§ 156.235(a)(2) – HHS should amend this section to apply to all QHPs regardless of whether they are in an FFE or an SBE.

We appreciate that HHS is proposing to incorporate standards from the annual Letter to Issuers into the ECP regulation. We urge HHS to apply these standards to all QHPs, not only QHPs in the FFM, and explicitly allow states to adopt more protective state-specific ECP and network adequacy standards for QHPs in the state.

RECOMMENDATION: We suggest that HHS amend this section as follows:

§ 156.235(a)(2): A plan applying for QHP certification ~~to be offered through an FFE~~ has a sufficient number and geographic distribution of ECPs if it demonstrates in its QHP application that ***it meets the higher of state ECP standards or—***

§ 156.235(a)(2)(i) – We applaud HHS’s clarification that multiple providers at one location count as a single ECP.

³⁰ See U.S. Department of Health and Human Services, Health Resources and Services Administration, “Find Shortage Areas: MUA/P By State and County,” available at <http://muafind.hrsa.gov>.

We particularly applaud HHS's clarification that multiple providers at a single location count as a single ECP for the purposes of satisfying the participation standard. This distinction helps to ensure more adequate networks that include a broader array of safety-net providers.

§ 156.235(a)(2)(i) – HHS should initially require QHPs to include 30 percent of ECPs and commit to increasing the percentage over time.

We support that QHPs must include in-network a specified percentage of available ECPs, with the percentage established annually in guidance. It is important to establish a federal floor while also providing flexibility for an increased percentage threshold, especially as access concerns and challenges evolve over time. To that end, we urge HHS to strengthen the ECP quantitative participation standard by adding regulatory language requiring that the standard continue to increase over time. NHeLP requests that HHS continue to encourage health plan issuers to work with a greater number of ECPs. Since many of the newly insured individuals seeking access through FFM plans were previously uninsured and accessed health care through the safety net, maintaining their ability to access their existing, trusted family planning providers and other ECPs is important.

With respect to the precise percentage that should be required, we urge HHS to start by requiring QHPs to demonstrate that at least 30 percent of available ECPs are included in their plan networks. HHS required QHPs in the FFM to comply with a 30 percent threshold this year, making it a reasonable starting point for future years. We also urge HHS to affirm that states may adopt stronger standards applicable to QHPs, above the HHS-established threshold, to address any specific access needs in the state.

RECOMMENDATION: We suggest that HHS amend § 156.235 as follows:

- (a)(2)(i): The network includes as participating providers at least ~~a minimum~~ **30** percentage, as ~~specified~~ **increased annually** by HHS, **or a higher standard set by the state**, of available ECPs in each plan's service area with multiple providers at a single location counting as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard; and

§ 156.235(a)(2)(ii)– HHS should clarify that issuers must enter contracts—not offer contracts—with ECPs.

NHeLP requests that HHS strengthen the ECP standard by requiring issuers to actually enter contracts with at least one ECP in each category for each geographic region it services. In 2014, many safety net providers who provide critical services to our clients were given only “low-ball” offers to participate in QHP networks, and were consequently left out. Since the goal of the ECP requirement is to ensure that consumers have meaningful access to these providers, we urge HHS to adopt a strong standard that

requires issuers to actually include at least one ECP in each category in each covered region.

NHeLP understands that there may be rare cases where QHP issuers are not able to reach an agreement with any ECPs in a particular category in a particular region. In these cases, we urge HHS to explicitly incorporate the good faith standard discussed in § 153.740(a) to ensure that QHP issuers have made real efforts to establish contracts with ECPs. We support HHS's clarification in § 153.740(a) that to be considered a good faith offer, a contract must offer rates and contract provisions that a "willing, similarly situated non-ECP provider would accept or has accepted." We urge HHS to clarify that good faith contract terms must include all of the services the plan covers and the ECP provides and include reimbursement at generally applicable payment rates. We are concerned that without additional clarification issuers could use a low-reimbursing contract as verification, forcing ECPs into lower reimbursement rate contracts. Without a strong requirement that QHPs make real efforts to establish legal agreement, the overall goal of the guidance will be eroded and QHP issuers will be able to evade the ECP standard by offering ECPs contracts but not following through on them. Moreover, HHS should encourage Exchanges to look closely at any QHP issuer that lacks contracts with ECPs, as that fact alone raises an inference that the issuer's offers have not been made in good faith.

RECOMMENDATION: We suggest that HHS amend § 156.235(a)(2)(ii) as follows:

- (ii) The issuer of the plan ***makes good faith*** offers ***of*** contracts, ***considering generally applicable payment rates and contract provisions that a willing, similarly situated non-ECP provider with median rates would accept or has accepted*** to—

§ 156.235(a)(3) – HHS should not permit QHP issuers to meet an alternate standard.

We urge HHS to eliminate the option that permits issuers to forgo the ECP standard completely by submitting a narrative justification that describes why they could not meet the standard but still have a network that is sufficient to meet the needs of low-income and medically underserved enrollees.

RECOMMENDATION: We suggest that HHS eliminate § 156.235(a)(3).

§ 156.235(c) – HHS should codify the preamble definition of family planning service sites in the regulation text.

We appreciate that HHS included a broad definition of family planning service sites in the preamble to the proposed rule. The clarified definition of ECPs includes "not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the Public Health Service Act." This distinction is particularly important as Title X dollars continue to decrease, and safety-net family planning health centers are forced to diversify revenue streams to remain viable and sustainable. Including these providers

regardless of their funding source will help to ensure a strong safety net that ensures that QHP enrollees have access to needed women's health services, including family planning and other preventive services. We urge HHS to include this clarification in the regulation text itself.

RECOMMENDATION: We suggest that HHS amend § 156.235(c) as follows:

- (c) An essential community provider is a provider that serves predominantly low-income medically underserved individuals, including a health care provider defined in section 340B(a)(4) of the PHS Act; or described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111-8, ***including not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act...***

§ 156.235 – HHS should clarify that the ACA's non-discrimination provisions apply to contracting with essential community providers.

The ACA prohibits issuers of group or individual health coverage to discriminate, with respect to participation, against providers practicing within their prescribed scope and under applicable state law. This protection is codified in regulation for QHP issuers at 45 CFR § 155.1050(c). This protection was specifically designed to prevent attempts to unfairly exclude or restrict certain providers—including women's health and family planning providers—from plans offered in the Exchange. NHeLP requests that HHS clarify that this protection applies to contracting with ECPs, and that issuers may not discriminate based on the services provided. Regrettably, there is already precedent of policymakers attempting to exclude specialized family planning health centers from Medicaid networks based solely on the types of services they provide. We are concerned that similar discrimination or tiering of providers might be occurring among issuers, as well as in state lists of ECPs. Reinforcing non-discrimination provisions in this context will help carry out Congress' intent and the precise goal of the ECP provision to ensure that consumers can access the full range of health care, including women's health services, through trusted ECPs in their communities.

RECOMMENDATION: We suggest that HHS add a subsection to § 156.235 as follows:

- (f) A QHP issuer in an Exchange may not discriminate in contracting with any essential community provider designated under subsection (c), including by refusing to contract with any essential community provider based on the services it provides or because it serves a particular population.***

§ 156.235 – HHS should ensure that QHP issuers rigorously monitor and enforce ECP participation in their networks.

As discussed in our comments to § 156.230(a) above, ECP standards must be rigorously monitored and enforced to be meaningful. HHS should require QHPs to

comply with monitoring and enforcement policies that ensure adequate oversight of QHP networks' compliance with ECP standards throughout the coverage year. HHS should require issuers to report any material changes to their ECP contracts within 30 days, and must ensure that at no time their network falls below the ECP minimum standards. In our comments to § 156.230(a), we ask HHS to codify specific network monitoring requirements in the areas of geo-access mapping, timely access reporting, and monitoring of internal and external appeals. We urge HHS require Exchanges to consider access to ECPs in any monitoring and enforcement that it undertakes related to network adequacy as a whole, in addition to monitoring for compliance with ECP standards separately.

§ 156.250 – Meaningful access to qualified health plan information

We support the proposal requiring QHPs to provide all information that is critical for obtaining health insurance coverage or access to health care services through the QHP, including applications, forms, and notices, to qualified individuals, applicants, qualified employers, qualified employees, and enrollees in accordance with the standards described in § 155.205(c). The preamble also requested comment on appropriate translation guidelines that entities serving the Exchanges should adhere to when translating important documents. We feel strongly that uniform guidelines should be provided to entities serving Exchange consumers so that they can use them to ensure they are meeting the needs of LEP consumers in areas they serve. We believe that all entities serving Exchange consumers should translate vital documents into any language spoken by 5% or 500 of the individuals in the entity's service area.

The 5%/500 thresholds are already employed in other federal agency policy guidance, with some programs and agencies employing even lower thresholds.³¹ HHS LEP Guidance currently uses a 5% and 1,000 person "safe harbor" threshold,³² which leaves out millions of limited English proficient individuals. As an example, when applying the 500 threshold to service areas measured by counties (which may not be the applicable service area for many of the entities covered by this proposed regulation), **1,324 counties** in the United States have populations of 500 or more limited English proficient individuals speaking at least one single language, as compared to only **987 counties** with populations of 1,000 or more limited English proficient individuals.³³ A 5 percent and 500-numeric threshold better ensures that the intent and statutory requirements to provide linguistically appropriate services will be met.

The service area may differ depending on the entity. For example, an insurer's service

³¹ U.S. Dep't of Labor, Style and Format of Summary Plan Description, 29 C.F.R. § 2520.102-2(c)(2) (2012); Supplemental Nutrition Assistance Program (SNAP), 7 C.F.R. § 272.4(b)(2)(i); U.S. Housing and Urban Development, Final Guidance to Receiving Federal Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 72 Fed. Reg. 2732, at 2753.

³² HHS LEP Guidance, 68 Fed. Reg. at 47,319.

³³ Migration Policy Institute analysis of American Community Survey Data, 2007–2011 (on file with NHeLP). It is noted that some language populations not comprising of 1,000 LEP individuals may still comprise 5% of the population.

area may spread throughout a state and should include both potential applicants and enrollees. A navigator's service area may be more targeted within a city or county and should include all individuals who may be seeking the navigator's services. Service areas relevant for the application of the thresholds should be entity-specific, encompassing the geographic area where persons *eligible to be served or likely to be directly or significantly affected* by the entity's program or activity are located. Where no service area has previously been approved, an entity may self-identify the service area, subject to showing that the service area does not discriminatorily exclude certain populations, and documentation of how the self-identifying determination was made and what data was used. As discussed in the HHS LEP Guidance, recipients should determine their service areas based on their actual experiences with LEP encounters as well as demographic data on the languages spoken by those who are not proficient in English.³⁴ HHS should consider equipping recipients with data driven maps that show estimates of eligible individuals with LEP for each service area as well as their approximate location.

It is also critical that translation be done by competent translators. HHS should advise covered entities to use only competent interpreters to translate all documents. Because all documents provided by providers and program administrators tend to have some consequence on the perceptions and actions of people who receive them, it is important to ensure that individuals do not receive erroneous information about available services.

Additional language access can be achieved by including taglines on all documents by those organizations covered by this regulation. The taglines should be in multiple languages noting that free interpretation services are available in all languages and providing the appropriate phone number and instructions on accessing the language service.

We also note that on documents providing vital information such as eligibility determination notices and termination notices, it is extremely important to use customized taglines that adequately represent the importance to call for language assistance because the content of the notice is vital. For example, a generic tagline that says something like "If you or someone you're helping has questions, call XXX-XXX-XXXX for language assistance. . ." is insufficient to convey the need to act, particularly on notices that require action such as payments or termination of coverage. We strongly recommend that entities produce notice-specific tagline that identify the type of notice. If notice-specific taglines are not possible, we suggest CCIIO require using the following tagline:

"IMPORTANT: This notice is time sensitive and may impact your eligibility for health insurance. You can get an interpreter at no cost to help you understand this notice. To get an interpreter or to ask about written information in (your language), call XXX-XXX-XXXX"

We also ask that HHS recommend placement of taglines to ensure they are not buried on the last page of notices where they likely will go unnoticed by LEP consumers who

³⁴ HHS LEP Guidance, 68 Fed. Reg. at 47,314.

are unlikely to review multiple pages of an English notice. Taglines should be prominent, up-front, and can even be added to the envelope in which materials are sent.

§ 156.280 – Segregation of Funds for Abortion Services

NHeLP strongly supports HHS' clarification of existing federal statutes and regulations regarding accounting and other standards for issuers of QHPs that cover abortion services. Section 1303(b)(2)(B) of the ACA, and its implementing regulations, require that QHPs covering non-excepted abortion services collect from federally subsidized enrollees a payment for an amount equal to the actuarial value of the coverage for non-excepted abortion services. As HHS explains in the preamble to these proposed rules, the law permits QHPs to satisfy this requirement in a number of different ways. States have some flexibility to implement these rules. Under the law, QHPs may issue to federally subsidized enrollees one, non-itemized bill indicating the total amount for all coverage provided under the plan. Federally subsidized enrollees may pay their bill (for non-excepted abortion services and for all other services) in a single transfer of funds. We also note that currently the preamble to the proposed rule refers to "enrollees" rather than "federally subsidized enrollees." We request that HHS correct this language in the final rule.

Indeed, a number of states have already issued guidance consistent with these rules. For example, the New York State Department of Financial Services Circular Letter to QHPs offered through New York's Health Benefit Exchange explains that "QHP issuers will be in compliance with the ACA if they do not itemize non-excepted abortion services on the premium bill and collect both premiums through a single transfer of funds."³⁵ Maryland has similarly made clear to QHPs that must comply with Section 1303 of the ACA and that the law does "not require[] [QHPs] to provide with separate invoices for non-excepted abortion services and all other services covered under a QHP, nor to provide enrollees with itemization on a single invoice for non-excepted abortion services and all other services covered under a QHP."³⁶ Washington has adopted regulations making clear that the law "does not require an issuer to conduct two separate premium transactions with enrollees."³⁷ NHeLP accordingly appreciates HHS' clarification of current law, which also reflects current state practice. We urge HHS to include these clarifications in a final rule.

RECOMMENDATION(S): We recommend amending § 156.280(e)(2)(i) as follows:

- (2) *Establishment of allocation accounts.* In the case of a QHP to which paragraph (e)(1) of this section applies, the QHP issuer must:
 - (i) Collect from each enrollee in the QHP (without regard to the enrollee's age, sex, or family status) a separate payment, ***which may be made through a single transfer of funds***, for each of the following:

³⁵ N.Y. DEP'T OF FINANCIAL SVCS., Insurance Circular Letter No. 7 (Sept. 18, 2013).

³⁶ MD. INSURANCE ADMIN., Bulletin No. 13-24 (July 31, 2013).

³⁷ WASH. ADMIN. CODE § 284-07-540(2)(c).

(A) An amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the QHP of services other than services described in (d)(1) of this section (after reductions for credits and cost-sharing reductions described in paragraph (e)(1) of this section); and

(B) An amount equal to the actuarial value of the coverage of services described in paragraph (d)(1) of this section.

(ii) Compliance with this section does not require the QHP issuer to itemize the services described in (d)(1) of this section on the premium bill.

(iii) Deposit all such separate payments into separate allocation accounts as provided in paragraph (e)(3) of this section. In the case of an enrollee whose premium for coverage under the QHP is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

§ 156.420 – Plan Variations

We support the proposal to require QHP issuers to provide a Summary of Benefits and Coverage (SBC) reflecting the cost-sharing charges associated with their CSR plan variations. This will help ensure that SBCs meet the goal of helping all enrollees — including those receiving cost-sharing reductions — to understand what they will pay when using covered benefits. Since the proposal would require issuers to provide these SBCs by the open enrollment period for the 2016 benefit year, we urge HHS to ensure that the CSR SBCs are made available to the public on Exchange websites and issuer websites during the same open enrollment period.

§ 156.425 – Changes in Eligibility for cost-sharing reductions

We support requiring QHP issuers making a plan change in accordance with §156.425(a) to provide an SBC to consumers reflecting the cost-sharing charges in the new plan variation within 7 days of receiving notification of such a change from the Exchange. When this occurs, QHP issuers should also be required to provide consumers with a notice explaining the change, why it is occurring, and how any cost-sharing amounts the consumer has already paid during the benefit year will be applied to the deductible and out-of-pocket limit of the new plan variation consistent with the requirements at §156.425(b). HHS should require such a notice and create a model notice that would communicate this information as clearly and simply as possible to individuals and families.

§156.815 – FFE Enforcement Remedies: Plan Suppression

We support the proposal for the FFM to suppress website information about plans in certain circumstances, such as when the insurer has submitted incorrect data, when the plan is about to be decertified by the FFM, or when there is a pending state

enforcement action that could affect the issuer's ability to enroll consumers. We recommend that in cases where a plan is suppressed, that HHS require the affected issuer to notify any consumer seeking to enroll in that plan about the suppression from the Exchange, including when a consumer is not seeking to enroll through the issuer or broker website. For example, if a consumer is attempting to enroll "through the Exchange" by working with an issuer (or a Web broker) over the phone, the issuer (or Web broker) should ensure the consumer does not miss out on advance premium tax credits or cost-sharing reductions by signing up for a suppressed plan. Similarly, people working in person with an insurer representative should be informed when a plan has been suppressed from the Exchange.

Conclusion

Thank you for considering our comments and recommendations. If you have any questions, please contact Leonardo Cuello (cuello@healthlaw.org) at the National Health Law Program.

Sincerely,

A handwritten signature in black ink that reads "Elizabeth G. Taylor". The signature is written in a cursive, flowing style.

Elizabeth G. Taylor
Executive Director