June 29, 2015

VIA ELECTRONIC SUBMISSION

Kevin Counihan
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

RE: Comments on May 29, 2015 CMS Bulletin on Proposed Out-of-Pocket (OOP) Cost Comparison Tool for the Federally-facilitated Marketplaces (FFMs)

Dear Mr. Counihan:

Thank you for the opportunity to comment on CMS' proposed Out-of-Pocket (OOP) Cost Comparison Tool outlined the May 29, 2015 Bulletin. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

Generally, we agree that this Tool adds a critical new mechanism for consumers to evaluate and select the most appropriate plan to suit their needs and may help them more easily weigh the effect of paying slightly higher premiums for lower cost sharing. For this reason, we encourage CMS to make the source code for this Tool available to State-based Marketplaces.

Our comments aim to indicate ways CMS can ensure the Tool provides an accurate and relatively complete projection of total costs and does so in a user-friendly, easy to understand format.

Factor in and Highlight Cost Sharing Reductions

First and foremost, we agree that any effective OOP calculator must incorporate and highlight any cost sharing reductions (CSRs) that may be available to individuals shopping for coverage. As you are aware, the current window-shopping tool defaults shoppers to

the bronze level plans with the lowest premiums. For consumers who qualify for CSRs, silver plans are a much better choice. Thus, we strongly support making silver plans the default plans that CSR-eligible consumers encounter when searching and reminding them of the benefits of choosing a silver plan when they compare or view other metal-level plans. We further support educating consumers about the importance of providing their household income when using the OOP Tool so that shoppers receive a realistic picture of what they might actually have to pay, including after factoring in CSRs. This will be especially important once the OOP Tool gets incorporated into the application process.

In addition, we recommend illustrating the out-of-pocket cost comparisons across plan levels using an initial results table similar to the table below that appears during the plan selection step of the online application. Assisters' experience is that this table helps consumers identify the level of plan that best meets their needs and budget during the plan selection process and highlights the benefits of silver level CSR plans. Adding such a table to the window shopping tool that includes the estimated out-of-pocket costs for each metal level (using a range as described below) could help consumers immediately identify the benefit of CSRs and selecting a silver-level plan.

Emphasize that the calculation is an estimate

The Bulletin articulates the concern that the data output for the OOP Tool could easily be misinterpreted as actual costs, rather than a projected estimate. To help address this issue, we agree that, at a minimum, the output values for OOP expenses should be presented as a rounded value. We suggest that the output values be rounded no more specifically than to the nearest hundred dollars. To further emphasize the fact that this is an estimate, we suggest that the Tool display a range rather than a single figure (e.g., $1,000 – 1,200). This approach would also require clear notice that the range is a projected estimate for an average user, not a definitive statement of future expenses. But we believe using a range with rounded numbers would minimize the chance that users mistake the estimated amount for a firm quote of how much they will actually spend out-of-pocket.

In any case, the Tool should clearly emphasize – likely in multiple places such as its homepage, the page where consumers input their utilization level, and the initial results page – that it is only an estimate based on average utilization and that it does not take into account OOP expenses for out-of-network providers.

Always show results for two scenarios: one based on expected utilization and a second based on a "bad year"

The Bulletin suggests two different options for assigning utilization levels: one that allows the user to select projected utilization for each household member, and a second that would produce an "average year" that defaults all enrollees to "medium" and projects a "bad year" result for the oldest household member. We understand that weighing these options involves balancing user-friendliness and convenience against the ability to customize the calculation to match actual household health status.

Given that past utilization may not be an accurate predictor of future health care needs (even for individuals with chronic conditions or disabilities as their health status may change year-to-year), we suggest a hybrid approach. We suggest using the first option, which allows consumers to select from three different utilization levels for each household member's expected use, but *also* including in the results an estimate that includes a "bad year" scenario where one or more household members have an unexpected illness or accident that requires significant care. The whole purpose of insurance is to provide a financial cushion in the event of unexpected events and unaffordable costs, and we believe that including a "bad year" projection helps ensure that enrollees factor that risk into their plan selection. We also suggest that the OOP includes language – in the introduction and perhaps on the results page – that a high utilization or "bad year" scenario is likely not going to account for the healthcare costs an individual with a chronic condition or disability is likely to face. For these individuals,

past or projected healthcare costs should guide how to select a plan rather than the results of the OOP.

We also note that in selecting an expected utilization level, the Tool should clearly explain that medications taken for chronic care, such as high blood pressure medications, would count as **one** prescription for each 30 day period or 12 prescriptions over the course of a yearlong treatment.

In all cases, we recommend separating premium from OOP costs. Alternatively, or perhaps for future iterations of the Tool if the data is available, we suggest developing a dropdown box that would calculate projected OOP costs for particular healthcare scenarios, such as an emergency department visit for an accident, a need for "specialty medications," or average costs for maternity coverage. This could help consumers further customize the estimate to match their needs and estimate risks without having to search each plan's Summary of Benefits and Coverage (SBC).

In the future, we also recommend considering ways for families to compare plans and costs side-by-side using different coverage groups. For example, a family of four may want to compare the out-of-pocket costs if they choose one family plan versus two plans (e.g., one coverage group for two adults and a second coverage group for two children).

Factor in effect of services that do not count to the deductible

Despite a decidedly mixed record of success in the literature, high deductible health plans are surging in popularity. One of the most confusing elements of these plans is that often a number of services are not subject to the annual deductible. So a plan may be structured to allow an enrollee to visit the doctor the first three times with only a copay even if they have not met the annual deductible. We urge CMS to ensure that the OOP Tool be able to distinguish the expected OOP burden between plans with deductibles that apply to nearly every service and those that exclude multiple services from the deductible. These differences are not trivial (particularly for low or moderate utilization) and accounting for them in the OOP computation would allow consumers to more easily see the differences between such plans (particularly when comparing costs for healthcare scenarios mentioned above) and serve a valuable educational purpose.

Include incremental as well as annual estimates

In our experience, many consumers are not aware of or misunderstand the differences between copays and coinsurance in relation to the deductible and the total OOP costs over the course of a year versus the initial costs to access needed services in the first month. This commonly comes up in situations with specialty drugs, where an individual in a high deductible plan may have very high initial costs and then have very low costs once the deductible or OOP maximum has been reached. Such high initial costs may be

prohibitive for some consumers and lead to gaps in care. Because the proposed OOP Tool's methodological approach is time based, we think it may be feasible, and certainly worthwhile, to present the costs over the first month (or two) in addition to the annual OOP costs. While the data would pull from the first calendar months, the tool should present this information to consumers as "cost the first time you fill a prescription or see a doctor." We recognize the need to not overwhelm consumers with too much information in the results display and thus would support including this additional information in a help text box explaining the annual OOP number. Alternatively, consumers could choose to filter plans by pre-deductible costs to see this information.

Terminology & Presentation of Results to Consumers

The OOP Tool should make the connection between the consumer's inputs and the estimated out-of-pocket cost clear. The results should display with a link to adjust the inputs and an explanation that these inputs affect out-of-pocket costs, but not premium prices.

We also suggest using consistent terms to refer to members of the household during input and on explanations of results. We think the existing window shopping tool's language should be replicated. The tool refers to "Person 1", "Person 2", etc. when inputting information and the plan results show "People Covered" and identify each person by number and age. We support adding gender and selected utilization level to the "person" description for the OOP cost results.

Similarly, the utilization levels should be described in terms that reflect how consumers interact with health care systems and avoid technical insurance terms. For example, say "visits to the doctor or physical therapist" instead of "provider visits," or "number of prescriptions filled" to notify consumers that "prescriptions" does not mean the number of medications. The best approach would be to focus-group and field test any specific language with HealthCare.gov users to identify confusing or difficult to understand phrases.

When displaying OOP cost information to users, we encourage CMS to show the consumer's out-of-pocket costs only and not the allowed charges. First, we note that based on the description in this RFI, the allowed charges would not reflect what an uninsured consumer can actually expect to be charged if she required health care services. The chargemaster rate is often considerably higher than the negotiated rate an insurance company pays, and so might actually underestimate the true value of the insurance policy for a given rate of utilization. Second, the Tool already presents consumers with a lot of information and we think that many consumers will be using this tool to compare their plan options rather than understand the value of health insurance in general. Thus, displaying information about the total allowed charges may either

confuse consumers or even deter some low-utilizers from enrolling because the full allowed charges appear more economical than paying monthly premiums.

Concerns with data and methodology

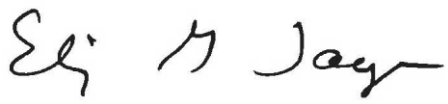
Lastly, we have several comments on the data set. We understand that the Marketplaces may have not been implemented for long enough to establish a robust utilization data set, but we urge CMS to move toward using base data from Marketplace Qualified Health Plan (QHP) enrollees rather than employer-sponsored insurance (ESI). ESI enrollees on the whole may well have different demographic characteristics and utilization patterns than Marketplace enrollees.[1] To the extent that actuaries can adjust for such demographic differences in the current ESI data set, we encourage CMS to do so.

We also noted that certain Essential Health Benefits (EHB) services, such as habilitation, are not listed in the OOP Tool benefit categories. More importantly, we are concerned that such EHB services may not be typically covered by ESI (which is not subject to EHB) or may be covered to a lesser extent and so may not be accurately represented in the ESI dataset. We encourage CMS to consider what, if any, impact such services might have on cost and utilization. This presents another reason why, in the long run, the best data for this Tool will come from Marketplace QHPs and Marketplace enrollees themselves.

Conclusion

Thank you again for the opportunity to comment. If you have any questions, please contact David Machledt (machledt@healthlaw.org) or Natalie Kean (kean@healthlaw.org), 202-289-7661.

Sincerely,



Elizabeth G. Taylor,
Executive Director

[1] Julie M. Donohue *et al.*, *Early Marketplace Enrollees Were Older and Used More Medication Than Later Enrollees; Marketplaces Pooled Risk*, 34 HEALTH AFF. 1049, 1051 (June 2015).