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Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 (CMS-9937-P/RIN 0938-AS57)

Dear Administrator Counihan,

Thank you for the opportunity to comment on HHS' proposed HHS Notice of Benefit and Payment Parameters for 2017 proposed rule. 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.

Preamble – Medicare notices (80 Fed. Reg. 75530)

We appreciate that HHS is seeking comment on ways to promote smooth coverage transitions between the marketplace and Medicare. The rules governing Medicare enrollment and eligibility, Marketplace enrollment, and Premium Tax Credit eligibility are complicated and can make the transition from one source of coverage to another difficult for enrollees.

For instance, individuals enrolled in Marketplace plans are not eligible for PTCs if they are eligible for minimum essential coverage, which includes Medicare.¹ However, individuals may not

¹ 26 C.F.R. 1.36B-2(a)(2) and 26 U.S.C. § 5000A(f)(1)(A)(i).

be aware they are eligible for Medicare, which can cause multiple problems. Individuals who do not know that they are eligible for Medicare and/or that Medicare eligibility means ineligibility for PTCs, may continue to receive APTCs after they become eligible for Medicare. These individuals will likely face an increased tax liability at reconciliation due to the APTCs received while eligible for Medicare. Further, individuals who do not timely enroll in Medicare coverage may face coverage gaps and enrollment penalties. Much of the burden of coordinating this transition falls onto the individuals and yet individuals do not receive sufficient notification or assistance as they make this transition.

We support the idea of pop-up notifications on HealthCare.gov for enrollees who will turn 65 during the benefit year. This is an important start, but we suggest further actions to promote smooth coverage transitions. Thus we also recommend sending specific notifications from Federal and State Marketplace for individuals enrolled in Marketplace plans who are already over age 65, for individuals enrolled in Marketplace plans who are receiving SSDI benefits and are nearing the end of their two year waiting period, and for individuals enrolled in Marketplace plans and are nearing age 65.

We also seek greater clarification as to how Marketplace plans coordinate with Medicare when individuals are eligible for Medicare and not enrolled, as well as for when individuals are both eligible for and enrolled in Medicare plans. Additionally, enrollees who are transitioning from a Marketplace plan to Medicare should receive clearer guidance of the steps they need to take, including when they need to enroll in Medicare, when they need to disenroll from the Marketplace plan, whether or not they need to contact their plan, and whether or not they need to contact the Marketplace. Enrollees currently receive unclear and inconsistent information on these steps.

§ 154.200 – Rate Review

HHS proposes to calculate rate increases for non-grandfathered plans with more precision, factoring in rating area, family size, age, and tobacco use. NHeLP supports this provision as it will make rate increase threshold decisions more accurately reflect the experience of consumers.

§ 155.170 – Additional Required Benefits

a. § 155.170(a)(2)—Benefit mandates

I. State Action

In the preamble, HHS indicates it will reword § 155.170(a)(2) to clarify that a benefit required by a state through *state action* on or before December 31, 2011 is considered an Essential Health Benefit (EHB). HHS proposes to adopt a broad interpretation of “state action”, which is not limited to state statutes, and includes state regulations and guidance as well. Since states often use state guidance or regulations to clarify existing coverage, it will be important for HHS to explain to states, in writing, the difference between creating a new benefit mandate and clarifying an existing benefit, so that this

proposed policy change does not inadvertently create unforeseen costs for the state. HHS should explain that a state will not have to defray the cost for clarifying how an existing benefit is covered.

II. State Benefit Mandates Policy

HHS indicates that the current state benefit mandate policy will continue to apply. Therefore, if a state requires a Qualified Health Plan (QHP) to offer benefits in addition to those included in the EHB base-benchmark plan (BBP), the state will have to defray the cost of covering the additional benefits with some exceptions. For example, state benefit mandates enacted on or before December 31, 2011 (even if not effective until a later date) are considered part of the EHB; therefore, states do not have to defray the cost of covering those benefits. But states are expected to defray the cost of state benefit mandates enacted on or after January 1, 2012, unless those mandates were enacted to comply with federal requirements.

HHS' current policy on state benefit mandates has effectively created a freeze on new state mandates because of the potential costs to the state. We urge HHS to create a process for states to address important market coverage gaps by allowing states to add new state-required benefits to the EHB without 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 needed mandates. For example, most of the final 2017 EHB benchmark plans do not cover certain services, including acupuncture, bariatric surgery, hearing aids, routine foot care, weight loss programs, and infertility treatment. By continuing to use a benchmarking approach to define the EHBs, HHS is passing on the responsibility to modernize and update benefit coverage to the plans that serve as benchmarks. Therefore it is important to allow states some way to improve benefit coverage to help meet the health goals of the state.

In addition, HHS should provide further guidance to states regarding the types of benefit mandates that a state may enact to comply with federal requirements that will not lead to additional costs.

RECOMMENDATIONS:

- *State Action:* If HHS adopts a broad interpretation of “state action”, which includes state regulations and guidance, we recommend that HHS explain to states *in writing* the difference between creating a new benefit mandate and clarifying an existing benefit to avoid the unintentional creation of new state benefit requirements for which states have to defray the cost.
- *State Benefit Mandates Policy:* We recommend that HHS create a process for states to address important market coverage gaps by allowing states to add new state-required benefits to the EHB without additional cost to the state. Some public process should exist to add needed mandates, and for states to improve benefit coverage to help meet the health goals of the state.

- *Exception to state mandate policy:* HHS should provide further guidance to states regarding the types of benefit mandates that states may enact in order to comply with federal requirements and that do not require defraying the cost.

b. § 155.170(a)(3) – Identification of State-Required Benefits in Addition to EHB

We commend HHS for proposing to designate the state, rather than the Exchange, as the entity that identifies which state-required benefits are in addition to EHB. As HHS noted, insurance regulators are generally more familiar with state-required benefits. Plus states are better suited to determine the appropriate entity to identify newly required benefits.

We also support, for consistency of terminology, HHS' proposal to replace the reference to "in excess of EHB" in paragraph (a)(3) with "in addition to EHB."

c. § 155.170(c)(2)(iii) – Issuer calculations attributable to additional benefits

We support HHS' proposal to designate the state (rather than the Exchange) as the entity that receives issuer calculations regarding the cost attributable to each additional benefit. The state has to defray the cost of any additional benefit; therefore this proposed policy change eliminates the unnecessary step of the cost attributions going to the Exchange first.

I. EHB Supplementing

In the preamble, HHS indicates that if a state supplements the EHB BBP, there is no requirement to defray the cost of the benefits added through supplementation, as long as the state imposes the requirement to comply with the ACA or other federal requirements. HHS provides some examples of areas where supplementation may be needed, e.g., to provide benefits in all 10 EHB categories. Yet, clearer supplementing guidelines are needed. In the Notice of Benefit and Payment Parameters for 2016 final rule (2016 Payment Notice), HHS noted that states retain the ability to determine whether the EHB BBP covers an EHB category or whether supplementing is warranted.² But for the most part, states are only supplementing when an EHB BBP does not cover *any* items or services in one of the ten EHB statutory categories. Therefore a plan with minimal or inadequate coverage in one of the 10 categories does not always get supplemented.

Other examples provided by HHS where supplementing may be warranted include: preventive services coverage, compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), and the removal of discriminatory age limits from existing benefits. While we appreciate this list of examples, states need further guidance

² HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750, 10,813 (Feb. 27, 2015) (hereinafter 2016 BPP rule), *available at* <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>.

regarding supplementation to meet federal requirements. Many of the final 2017 EHB benchmark plans are not yet in compliance with these federal requirements. It is also critical to remedy any discriminatory benefit design, e.g., a number of states only cover hearing aids for children. Based on HHS' examples, it appears that those states can remove age limit restrictions and provide hearing aid coverage for adults through the supplementation process without having to worry about creating a new mandate or defraying the cost.

RECOMMENDATIONS:

1. HHS should clarify that states may supplement when there is *insufficient* or *inadequate* coverage of an EHB category.
2. HHS should provide states with further guidance on how to use supplementing to bring the final 2017 EHB benchmark plans into compliance with federal requirements such as preventive services coverage, compliance with the MHPAEA, and removal of discriminatory age limits.
3. HHS should explain that if a state supplements the EHB BBP, there is no requirement to defray the cost of the benefits added through supplementation, as long as the state imposes the requirement to comply with the ACA or another federal requirement.

II. Habilitative services

In the preamble HHS notes that the 2016 Payment Notice specified that “a state may need to supplement habilitative services if the base-benchmark plan does not cover such services.” HHS should mention that a uniform definition of habilitative services was established to be used beginning with the 2016 plan year.³ If the EHB BBP selected does not provide coverage of habilitative services or provides inadequate coverage, states may define the benefit, but must use the uniform definition as a minimum standard. If the state does not define the benefit, issuers will cover habilitative services and devices as defined in the uniform definition.

In addition, HHS should clarify the policy on habilitative services mandates. In the 2016 Payment Notice, HHS indicated that new state benefit mandates enacted to define habilitative services are part of the EHB, so states do not have to defray the cost for those mandated benefits.⁴ More than half of the final 2017 EHB benchmark plans do not appear to cover hearing aids. Therefore, if states do not have to defray the cost for enacting a hearing aid mandate as part of the definition of habilitative services, that information should be clearly explained in this 2017 Notice to states.

RECOMMENDATION: HHS should clarify, in writing and with examples, that state benefit mandates enacted to define habilitative services are part of the EHB and states do not have to defray the cost for those mandated benefits.

³ 45 C.F.R. § 156.115(a)(5)(i)

⁴ 2016 BPP rule, *supra* note 2, at 10,811-12.

III. Effect of State-Required Benefit in the Large Group Market

In the proposed rule, HHS indicates that if a state selects as their BBP a health plan option that includes a benefit mandate that 1) was enacted after December 31, 2011, 2) directly applies to QHPs, and 3) was not enacted for purposes of compliance with federal requirements, then that specific benefit is not an EHB, so the state will have to defray the cost of covering the benefit, even if it is now embedded in the plan the state selected as its BBP.

Yet, HHS clarifies that if a state enacted a benefit mandate after the December 31, 2011 deadline that only applies to large group plans, and then the state selects a large group plan as the state's EHB BBP, then the new mandate is considered part of the benchmark and the state does not have to defray the cost. We support HHS' reasoning for this policy because the large group market mandate did not directly apply to QHPs when it was enacted. We encourage HHS to also clarify that this same policy applies to state employee plans that get selected as the EHB BBP. This will provide clarity to states that have selected a state employee plan as their BBP for 2017 and for states that consider doing so in the future.

RECOMMENDATION: Similar to the policy outlined for large group market mandates, HHS should clarify that if a state enacts a benefit mandate that only applies to state employee plans after the December 31, 2011 deadline, and then the state selects a state employee plan as the state's EHB BBP, the new mandate is considered part of the benchmark and the state does not have to defray the cost.

IV. Changing small employer definition and impact on mandates

HHS noted that several states have enacted benefit requirements that apply to insurance plans offered to employers with 51-100 employees, but not to employers with 1-50 employees. HHS also indicated that states that elected to expand the definition of small group employer (from 1-50 to 1-100 employees) would be required to defray the cost of benefit mandates applying to plans offered to employers with 51-100 employees, if the benefit requirement was required by state action taking place on or after January 1, 2012.

However, HHS should not require a state that enacted benefit requirements that applied to employers with 51-100 employees, and thereafter elected to expand the state definition of small employer, to defray the costs of the new benefits required for the small group market. Since HHS' clarification of a state's obligation to defray was released *after* a state's decision to expand the small employer definition, this policy would penalize states that were unaware that a change in the definition of small group employer would trigger a state obligation to defray costs.

RECOMMENDATION: HHS should not require a state that enacted benefit requirements that applied to employers with 51-100 employees, and thereafter elected to expand the state definition of small employer, to defray the costs of the new benefits required for the small group market.

V. General Comments on Essential Health Benefits

A. Benchmarking approach

Forty-six states and D.C. have a small group plan as their final 2017 EHB benchmark, either by state selection or assigned by default. As a result, most benchmarks do not cover certain services, and there is inadequate coverage of EHB statutory categories, including harmful treatment limitations and exclusions impacting access to care.

The benchmarking approach has also produced inconsistency in how EHBs are covered. For example, states are not supplementing EHB categories when needed. Also many of the final 2017 benchmark plans are not in compliance with existing EHB requirements (e.g., mental health parity, preventive services, etc.). Also, since they are based on 2014 plans, the 2017 benchmarks are also not in compliance with new EHB standards that go into effect in 2016 and 2017 (e.g., prescription drug requirements), making oversight and enforcement by HHS critical.

NHeLP continues to oppose the use of a benchmarking approach to define the EHBs. There is a clear directive in the Affordable Care Act *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. See 42 U.S.C. § 18022(b)(1). HHS must move towards compliance with the law and develop a strong federal standard to ensure covered populations can access comprehensive care that consistently meets their needs. We commend HHS for establishing a uniform definition of habilitative services, but this is not enough. We urge HHS to establish a minimum definition for the remaining EHB categories.

RECOMMENDATION: 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, which states can expand upon, for all EHB statutory categories by a set date.

B. Substitution of Benefits

Unless prohibited by state law, issuers offering EHBs are permitted to substitute benefits that are 1) actuarially equivalent to benefits replaced; and 2) within the same EHB category. As a result, issuers may substitute services that certain populations (e.g., individuals with chronic conditions) need and replace them with actuarially equivalent services, which may be less costly and more likely to attract healthier populations.

Allowing issuers to substitute benefits within an EHB category makes it difficult for consumers to compare health coverage options, making plan selection challenging. In addition, without a standard set of EHBs that issuers must cover, it is unclear how state regulators are ensuring adequate coverage of EHBs. While states have the option to

adopt more stringent standards that limit or prohibit this type of substitution, only a few states have prohibited benefit substitution.

RECOMMENDATION: We urge HHS to eliminate any provision allowing issuer flexibility to substitute benefits.

We continue to be deeply concerned with the adequacy of benefits for children in plans listed in the Exchange. Families' experience with private insurance and its lack of adequate pediatric benefits force us to reiterate our strong belief that Essential Health Benefit (EHB) rules should establish a broader definition of pediatric services that includes the full range of services children need for healthy development. At a minimum, the definition should be based either on the benefits provided in a state's CHIP plan or on the American Academy of Pediatrics' Scope of Health Care Benefits for Children.⁵ CHIP benefits are specifically tailored to children and meet their continuous, and changing, growth and developmental needs. States should be required to assess the pediatric benefits that are included *and excluded* from their selected benchmark and use their CHIP benefits or those included in the Scope of Health Benefits to supplement as needed so the plan fully covers pediatric services.

To strengthen this proposal further, we recommend that the "set of EHBs" separate pediatric services from those for adults. Families with relatively healthy children, as well as those with children who suffer from serious, chronic or complex condition, face unique challenges both in terms of plan decisions and financial implications of care. We also urge HHS to add habilitative services to the services exempted from the deductible, rather than limiting the exemption to rehabilitative services. Coverage of habilitative services and devices is a critically important benefit for children who may suffer from a condition at birth (such as cerebral palsy, autism or spina bifida) or from an illness or injury that prevents normal skills development and functioning. Standardized cost sharing structures for these services should be incorporated into the options to both inform consumer choice of plan and the potential financial impact of the use of these important therapies.

C. 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. While we appreciate that HHS has posted supporting plan documents for the final 2017 EHB benchmark plans, many times these documents refer to additional documents for coverage details, e.g., durable medical equipment formularies, benefits schedules, or appendices which are not included with the plan documents, but are needed in order to figure out what benefits are covered by the plan.

⁵ COMMITTEE ON CHILD HEALTH FINANCING, Scope of Health Care Benefits for Children From Birth Through Age 26 [PEDIATRICS, January 2012, VOLUME 129 / ISSUE 1](#)

Also, evidence of coverage and certificate of coverage documents generally are confusing or incomplete, and many times these documents include multiple amendments which make it difficult to determine covered benefits. The level of detail in the benefits and limits charts provided for each state along with the plan documents varies significantly from state to state, with most states simply indicating whether a benefit is covered. The charts should be amended to provide an accurate picture of covered benefits and, thus, include specificity about covered benefits and limits. This way everyone will understand exactly what benefits are included in the BBP and how they are covered. Also, with more detail, the charts could even become a helpful tool for state regulators to ensure coverage of EHBs by health plans and issuers.

HHS should also set-up a process for continued feedback from advocates and stakeholders regarding the EHB benchmarks to help with monitoring and enforcement of the EHB requirements.

RECOMMENDATION: We recommend that HHS require states/issuers to include plan documents **and** any referenced documents that provide coverage details for the state's benchmark plan, and that all of those documents (including formularies and appendices) get posted on the CCIIO website.

In addition, HHS should 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. To promote clarity and plan compliance with the EHB standard, the benefits and limits charts should also be updated to include some of the coverage details in the plan documents. The charts should also include information regarding all covered benefits in the benchmark plan instead of just categories of benefits (e.g., hospitalization services, substance abuse disorder outpatient services, etc.)

§ 155.200 – Functions of an Exchange

We appreciate the requirements of a state exchange using the federal platform to have to comply with the listed requirements, in particular network adequacy, formularies, essential community providers, meaningful difference, QHP issuer compliance, and casework.

We also agree with incorporating subpart M and O, which, as HHS recognizes in the preamble, include important consumer protections. Certainly all Exchanges should comply with these standards.

Regarding SBE-FPs, we support the requirement that the SBE-FP must have standards that are at least equivalent to the requirements that apply to the FFE's QHPs and issuers for oversight. Again, this is an important consumer protection to ensure consumers are not worse off merely because their state undertook some but not all function of an Exchange. In addition to the requirements listed, we also suggest including a requirement that the state's standards, and thus the QHP and issuer compliance, include compliance with all relevant civil rights laws and regulations

including Section 1557 of the ACA, Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, Title VI of the Civil Rights Act and the Age Discrimination Act. QHPs and issuers in a SBE-FP should also explicitly be required to comply with the language access requirements finalized in the 2016 Benefit and Payment Parameter rule.

§ 155.205 – Consumer Assistance Tools and Programs of an Exchange

a. § 155.205(a) & (b)(7) – SBE-FP Telephone Hotline and Web Site

We support the proposal to exempt SBE-FPs from operating a call center because they rely on HHS to carry out call center functions. We also support requiring SBE-FPs to operate both a toll-free telephone hotline and an informational Web site to respond to their state's consumers' requests for assistance and to direct consumers to application and enrollment assistance and FFE tools as necessary. We recommend further defining "toll-free telephone hotline" and clarifying the minimum services such hotline is required to provide.

We also recommend that CMS require that each state's Medicaid program (and where applicable CHIP program), and particularly those of SBE-FP's, include a link to the Web site where consumers can apply for marketplace coverage. While the "no wrong door" policy should link consumers who apply but are determined ineligible for Medicaid/CHIP to the FFE, a consumer may get to the state's Medicaid/CHIP Web site but learn that he is not eligible (without filing an application) and thus should be provided with information on other coverage opportunities.

b. § 155.205(d)(1) – Training Prior to Performing Any Consumer Assistance Function

We support requiring any individual or entity carrying out consumer assistance functions in any Exchange to complete training prior to performing any assister duties, including before conducting outreach and education activities, as well as before providing application and enrollment assistance.

However, we also recognize that the timing of the assister training availability limited some assisters from conducting outreach and enrollment work while awaiting relaunch of the training. Therefore, we recommend exempting assisters who are eligible to be recertified from the requirement to complete recertification training prior to conducting outreach and education. We recommend amending § 155.205(d)(1) as proposed but separating the "outreach and education activities" language from the "carrying out consumer assistance functions" language in § 155.215(b)(1)(i).⁶

In future years, we also recommend the training be available at least two months prior to open enrollment so that new assisters can complete the training and begin assisting

⁶ Dep't of Health & Human Servs., Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 75523 (proposed Dec. 2, 2015).

consumers well in advance of open enrollment, since we now contemplate a broader role for assisters. This is also important for assisters who may move between organizations but continue in an assister role. This past year, these assisters had to retake the entire training before assisting consumers even though they previously completed the training through another entity.

§ 155.210 – Navigator Program Standards

We support HHS seeking to target underserved and vulnerable populations and better serve consumers' need for assistance beyond the application and enrollment process. We support enhancing the role of Navigators in providing this consumer assistance. However, we also strongly urge HHS to invest in Consumer Assistance Programs (see 45 C.F.R. § 155.205) to assist Navigators in meeting these new requirements. Because Consumer Assistance Programs (CAPs) have been assisting consumers with health insurance literacy and filing appeals for years, HHS should re-engage with these entities and provide funding to them. We think that supporting CAPs and fostering a relationship between Navigators and CAPs will best ensure Navigators can meet these new requirements and consumers have access to all the skilled post-enrollment assistance they may need.

Additionally, we request that HHS update and republish their current regulations and guidance surrounding the use of personally identifiable information (PII) to clarify whether Navigators are permitted to collect, disclose, access, maintain, store and/or use PII to carry out these proposed post-enrollment activities. Making Navigators aware that they can keep and use PII is critical to ensuring they carry out these post-enrollment activities. We understand that CMS recently updated the model Navigator consent forms to allow consumers to authorize Navigators to use PII to follow up with consumers for certain post-enrollment needs. However, our experience working with assisters has informed us that many Navigators do not keep any PII after an enrollment appointment other than the authorization form itself. Therefore, we request that HHS formally republish and update PII guidance to make explicit that Navigators can keep and use PII to engage in post-enrollment assistance.

a. § 155.210(b)(2) – Training

We strongly support requiring Exchanges to develop and disseminate training standards for Navigators that ensure expertise is the newly proposed post-enrollment assistance duties outlined in § 155.210(e)(9). We recommend amending the following proposed language in § 155.210(b)(2) to correspond to our recommended amendments to § 155.210(e)(9), as discussed below.

RECOMMENDATION: We recommend amending § 155.210(b)(2)(v)-(viii) as follows:

- (v) ***The right to appeal Exchange eligibility determinations and the general*** process of filing Exchange eligibility appeals;
- (vi) General concepts regarding exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment, including the application process for exemptions granted through the Exchange, ***IRS Form 8965), associated Exchange tools,*** and IRS resources on exemptions;
- (vii) The Exchange-related components of the premium tax credit reconciliation process, ***including all versions of IRS Form 1095,*** and IRS resources on this process; and
- (viii) Basic concepts ***and rights*** related to health coverage and how to use it, ***including, at a minimum:***
 - (1) key health insurance terms and how they relate to the consumer's health plan;***
 - (2) the cost and care differences between a visit to the emergency department and a visit to a primary care provider under the coverage options available to the consumer;***
 - (3) how to identify in-network providers and covered prescriptions;***
 - (4) how the consumer's coverage addresses post-appointment steps such as making follow-up appointments, getting lab work and ordered tests, and filling prescriptions;***
 - (5) the right to coverage of certain preventive services without cost sharing; and***
 - (6) nondiscrimination protections.***

d. § 155.210(d)(6) – Gifts

We support simplifying the rule on when gifts and promotional items can be provided to applicants and potential enrollees. We agree that assisters are generally confused about when gifts and promotional items can be provided. We believe the proposed language clarifies the rule and strikes the right balance between allowing assisters to use gifts and promotional items in outreach while ensuring they are never used to induce enrollment. In particular, we support the language clarifying that reimbursement of legitimate expenses, such as travel or postage expenses, is not considered a gift. To make this rule more transparent, we recommend including simple examples of permissible and impermissible gifts, promotional items, and legitimate expenses in both the final rule (similar to IRS' final regulations) and assister training.

e. § 155.210(e)(8) – Targeted Assistance to Underserved Populations

We support requiring Navigators in all Exchanges to provide targeted assistance to serve underserved and/or vulnerable populations while maintaining their duty to serve any consumer seeking their assistance. We commend HHS for prioritizing assistance to these populations and agree that providing them with targeted assistance is critical to

improving their access to health care. Furthermore, we recognize, as HHS does, the important goal of reaching populations who have significant medical needs, are disproportionately affected by disease, or face barriers to accessing coverage and care. We also strongly support allowing each Exchange to identify the underserved and vulnerable populations in its service area and agree with the approach of allowing applicants for Navigator grants to propose the populations it will target. We think the proposed criteria to identify these populations in FFE service areas are appropriate as they separate lack of access to coverage or care from being at greater risk for poor health outcomes. While both criteria may often characterize the same population, we think it is important that Navigators recognize each of the criteria separately in identifying the populations most in need of assistance.

Regarding the timeframes for identifying these populations, we recommend that Exchanges regularly engage in their chosen process to identify these populations. In the FFE, Navigators should be asked to propose additional populations needing targeted assistance each time they apply for the grant and HHS should review previously identified populations currently being served to determine if they continue to need targeted assistance. To the extent that serving new underserved populations will require additional training or resources, we recommend identifying these populations at least 3 months prior to the beginning of open enrollment to allow sufficient time for these activities to occur.

We also recommend that HHS identify additional training and resources that would be helpful to navigators who will serve these populations. A navigator entity may not have direct experience working with a particular underserved population and thus its staff would need additional training to effectively conduct outreach and enrollment activities. For example, during OE3 a focus has been placed on enrolling the Latino population. We appreciate this focus since large numbers of the remaining uninsured are Latino. However, many navigator entities may not have the cultural or linguistic experience to effectively outreach and enroll this population. In this case, providing direct training for entities on how to provide culturally appropriate outreach, how to work with ethnic media, how to identify competent interpreters and how to work with interpreters, and how to competently translate materials would all be knowledge required *prior* to initiating a focus on this population. Additionally, as navigators are already under-resourced, additional funds to provide targeted activities to this population would be important, particularly if it required hiring bilingual staff and/or competent interpreters. So to the extent that HHS will be identifying a particular underserved population in future years, we recommend that part of the planning process include identifying additional resources, materials and funding that will be needed to effectively conduct this assistance and that HHS directly work with navigator grantees to determine their needs prior to implementing a new requirement.

We also agree with HHS's decision not to propose extending this requirement to certified application counselors and non-Navigator assistance personnel for the same reasons HHS identifies, although it would be helpful for HHS to educate these entities about the targeted assistance and how they can support navigators' efforts.

f. § 155.210(e)(9) – Post-Enrollment Assistance

We commend HHS for seeking to serve consumers' need for assistance beyond the application and enrollment process using existing consumer assistance programs. We know that Navigators are currently permitted to, and many are in fact providing, the types of post-enrollment assistance HHS proposes requiring them to provide. We believe that codifying these duties will further encourage Navigators to maintain relationships with consumers post-enrollment and across coverage years. Such relationships can greatly enhance consumer experience and may be vital to successful enrollment, coverage utilization, and coverage continuity for some consumers.

I. Appeals

Furthermore, as the preamble states, it is important for consumers to have access to skilled assistance beyond applying for and enrolling in health coverage and Navigators are uniquely situated to provide some of this assistance.⁷ However, we have concerns about the scope of skilled post-enrollment assistance HHS proposes Navigators should provide. In particular, we are concerned with the proposed language requiring Navigators to provide information and assistance with the process of filing Exchange eligibility appeals. We acknowledge that HHS is not proposing to establish a duty for Navigators to represent a consumer on appeal, sign an appeal request, or file an appeal on the consumer's behalf and agree that Navigators can play a role in helping consumers understand their appeal rights and the general process. However, as explained below, we think the proposed language in paragraph (e)(9)(i) needs to be amended to clarify the duty that is being established.

We propose that Navigator's duty with respect to eligibility appeals be limited to making consumers aware of their right to appeal, providing basic education on the appeals process, and making appropriate referrals for legal assistance when possible. Eligibility appeals concern consumers' legal rights that can be compromised without proper legal representation. Additionally, we think that requiring Navigators to provide information and assistance with the process of filing Exchange eligibility appeals puts Navigators at risk of conflating their role as Navigator with that of a legal representative. This conflation of roles could lead Navigators to act beyond their permissible scope of assistance by advocating for the consumer and would put consumers at risk of not receiving adequate legal advocacy. We also think the rule should clearly define the type of assistance Navigators provide with respect to eligibility appeals to help both Navigators and consumers recognize where a Navigator's assistance stops and legal assistance becomes appropriate or necessary.

HHS has done a good job of educating assisters (and the consumers they serve) that assisters are not tax advisors and cannot serve in that role. However, due to the overlap of eligibility and appeals of eligibility determinations, many non-legal assisters do not fully understand where their assister role should end and a legal representative relationship should begin. This is heightened by the use of the term "authorized

⁷ *Id.* at 80 Fed. Reg. 75,520.

representative" in both the HealthCare.gov application and the appeals process. In the former, it recognizes that an assister may have a role in communicating with the Call Center or about a consumer's application to assist in obtaining an eligibility determination. But by using the same terminology in the appeals process, where an authorized representative typically should be limited to legal counsel, many assisters lack the understanding that representing the consumer in an appeal could actually compromise the consumer's legal rights since the assister generally does not have the requisite knowledge, skill or abilities that a lawyer has when accepting a case for a consumer. Thus it is essential that HHS educate assisters further about the appeals process and the legal rights at stake for a consumer so that assisters can further educate consumers who may wish to seek out legal representation (particularly since many consumers would be eligible for free legal assistance from a legal aid organization) rather than rely on the assister through the appeals process. We certainly recognize and appreciate that an assister can help facilitate an appeal but just as we have educated assisters not to take on the role of a tax adviser, we should also just as strongly educate assisters not to take on the role of a lawyer.

For example, when a lawyer takes on representation of a client, the lawyer will perform a conflicts check and also maintain sufficient documentation to proceed with the case. Many assisters are still concerned about keeping PII and may not keep files sufficient to follow through with all steps of an appeal. Further, when a lawyer agrees to represent a client, the lawyer effectively takes on the representation until a final resolution is reached and the client, hopefully, is made whole. Assistors, whose primary responsibility is to enroll consumers, likely will not have the time or ability to effectively represent all consumers throughout an appeals process, especially during busy times of open enrollment periods or tax season. The lawyer-client relationship has many guideposts to protect the rights of the client and ensure effective representation. An assister helping a consumer with an appeal is not subject to those same requirements and thus the consumer's rights may end up in jeopardy.

We certainly are not intending to undermine the role of the assister in educating consumers about the appeals process. And indeed some consumers, armed with this education, may choose to have the assister represent the consumer. But without sufficient education, both the consumer and assister may inadvertently be entering into a relationship that will not be in the best interest of either.

We encourage HHS to help FFM Navigator grantees identify methods of establishing relationships with local legal services organizations to help with the appeals process. Perhaps in the second and third year of funding, a FOA requirement could be to establish such a relationship and funding could be dedicated to ensure the availability of legal services assistance to consumers seeking help with appeals after enrolling. Many consumers will be eligible for free legal assistance and legal services may be able to, with appropriate referrals, assist these consumers with the appeals process. Further, many Navigator entities would benefit from an ongoing relationship with a local legal services organization which could assist in training assisters and helping them spot issues that may lead to the need to file an appeal. We recognize that just as many Navigator entities are under-resourced, so too are many legal services entities. That is

why it would be critical for the Navigator entity to affirmatively reach out and explore the possibility of a relationship rather than just begin to refer all consumers to a local legal services entity.

II. Exemptions

We support the proposed requirements with respect to Navigators' duties to provide information and assistance with: understanding and applying for exemptions from the individual share responsibility requirement that are granted through the Exchange, understanding the availability of exemptions that are claimed through tax filing and how to apply for them, and understanding the availability of IRS resources; understanding the Exchange-related components of the premium tax credit reconciliation process and the IRS resources available; understanding basic concepts related to health coverage and how to use it; and referrals to licensed tax advisers, tax preparers, or other resources for tax preparation assistance and advice. We think the proposed language for these duties appropriately identifies the IRS and tax advisers and preparers as sources of skilled assistance on tax-related matters.

We think adding the phrase "and rights" to the requirement to provide assistance with understanding basic concepts related to health coverage and how to use it is sufficiently specific. We agree that the assistance would vary depending on each consumer's health insurance literacy, needs, and goals and thus specifying topics Navigators are required to assist with seems unnecessary. We believe that Navigator training is the best format for specifying the range of health insurance literacy topics Navigators should be prepared to assist with and thus recommend language to add to § 210.155(b)(2)(viii) accordingly.

Additionally, before requiring Navigators to provide assistance with additional health insurance literacy topics, we urge HHS to provide additional information or referrals to resources where assisters can become knowledgeable of these issues. In particular, many of the assisters we work with report that they often contact issuers to obtain information on specific plan benefits, terminology, or services. We are also aware that issuers often provide additional training and materials to agents/brokers about their plans. We recommend that HHS require issuers to provide information to assisters regarding plan benefits and details to increase Navigators' ability to assist with health insurance literacy.

We recommend adding language to further clarify the duty with respect to exemptions as discussed in the preamble.⁸ In particular, we think the rule should state the assisters are required to inform consumers about the requirement to maintain minimum essential coverage and the individual shared responsibility payment. We also think the rule should specify that Navigators' should be aware of and help consumers use the Exchange tool to find bronze plan premiums and help consumers understand the general purpose IRS Form 8965.

⁸ *Id.* at 80 Fed. Reg. 75,521.

Similarly, we recommend adding language to paragraph (e)(9)(iii) to specify that Navigators are required to help consumers access and understand Form 1095-A generally, understand how to report errors on Form 1095-A, and how to find silver plan premiums using the Exchange tool.

RECOMMENDATION: We propose amending § 155.210(e)(9) as follows:

- (9) Provide information and assistance with—
- (i) ***Understanding the right to appeal an adverse Exchange eligibility determination, the basic*** The process of filing Exchange eligibility appeals, ***and the availability of Exchange resources on this process, and referrals to legal assistance where available;***
 - (ii) Understanding ***the requirement to maintain minimum essential coverage and the individual shared responsibility payment; understanding*** and applying for exemptions from the individual shared responsibility requirement that are granted through the Exchange; understanding the availability of exemptions from the requirement to maintain minimum essential coverage and from the individual shared responsibility payment that are claimed through the tax filing process and how to apply for them; and understanding ***the general purpose of and where to access IRS Form 8965, the Exchange tool to find bronze plan premiums, and*** the availability of IRS resources on this topic;
 - (iii) Understanding the Exchange-related components of the premium tax credit reconciliation process, ***accessing and understanding IRS Forms 1095 generally, understanding how to report Form 1095 errors and use the Exchange tool to find silver plan premiums,*** and the availability of IRS resources on this process;
 - (iv) Understanding basic concepts ***and rights*** related to health coverage and how to use it;

We do not think it is necessary to limit Navigators' duty to provide exemption application assistance and appeal process assistance to certain consumers. We believe HHS' stated objective of ensuring consumers who are unable to access coverage have experienced assistance available to help with exemptions outweighs concerns about reducing available help for consumers seeking coverage. To further alleviate the concern, HHS could specify that Navigators prioritize helping consumers with applying and enrolling in coverage during open enrollment over helping consumers seeking exemptions. However, we believe the additional burden this new requirement places on Navigators will be minimal and it is not clear that any limitation is necessary. Therefore we recommend HHS revisit this proposal in the future.

We think that HHS should require Navigators to provide consumers with a disclaimer stating that they are not acting as tax advisers and cannot provide tax advice within their capacity as Exchange Navigators. As the preamble indicates, such disclaimer would help avoid consumer misunderstanding that information a Navigator provides is tax

advice and avoid potentially detrimental reliance on such information.⁹ We also recommend requiring a similar disclaimer regarding appeals to state that Navigators are not acting as legal representatives and cannot provide legal advice or advocacy with their capacity as Exchange Navigators. Additionally, we think that requiring Navigators to provide these disclaimers before providing any application, enrollment, or post-enrollment assistance is practical and will minimize potential confusion by setting out the Navigator's duties and capacities at one time. Therefore, we recommend including these disclaimers in the model authorization form for Navigators.

We also recommend HHS make explicit the interpretation of § 155.210(e)(1) and (2) to mean that Navigators may educate consumers about their rights with respect to coverage available through the Exchange by including them in the topics on which Exchanges are required to train Navigators under § 155.210(b)(2). We have recommended such additional language above.

We do not think that the § 155.210(e)(9) proposed requirements to assist with post-enrollment and other activities should be extended to certified application counselors or non-Navigator assistance personnel. As HHS recognizes, these assisters are permitted to help with these activities to the extent they are consistent with their existing duties. And as discussed below with the other proposed standards applicable to certified application counselors, these types of assisters' engagement in assister duties tends to be more dynamic than Navigators'. They are also more likely to be limited in terms of time and resources and therefore imposing additional substantive duties may limit their ability to perform their existing enrollment duties.

§ 155.215 – Training Prior to Performing Any Consumer Assistance Function

As discussed above, we recommend amending § 155.215(b)(1)(i) to exempt assisters who are eligible to be recertified from the requirement to complete recertification training prior to conducting outreach and education.

RECOMMENDATION: We recommend amending § 155.215(b)(1)(i) as follows:

- (i) *Obtain certification by the Exchange prior to carrying out any consumer assistance functions ~~or outreach and education activities~~ under § 155.205(d) and (e) or § 155.210, **except that any individual eligible to be recertified is not required to obtain certification prior to carrying out outreach and education activities;***

⁹ *Id.* at 80 Fed. Reg. 75,521.

§ 155.220 – Ability of States to permit agents and brokers to assist qualified individuals qualified employers, or qualified employees enrolling in QHPs.

We have some concerns about the scope of what web brokers may be permitted to do and think that clear requirements and consistent enforcement of federal rules for all web brokers is necessary, as confusion surrounding expectations and a lack of consistent enforcement does not serve consumers well.

a. Streamlined Eligibility Application Integration

We recommend HHS not allow an option that permits consumers to complete their application and enroll directly through web-based entities without first being directed to an Exchange site. Exchanges are a cornerstone of the Affordable Care Act and crucial to its success. The value of going through the Exchange websites for eligibility determinations should not be lightly discarded. Without an initial interface with an Exchange, there is a strong likelihood of future confusion when the consumers get communication from the Exchange. They will not have any connection and may disregard notices from the FFE or state-based Exchanges, for example regarding inconsistencies, needed verifications, and 1095-A statements. Retaining a requirement that consumers complete their application and enrollment through an Exchange ensures that they establish an identifying relationship with the Exchange.

Moreover, establishing the initial relationship with Exchanges ensures that consumers receive completely unbiased information, without the influence of particular issuers that web-based entities may carry given their potential contractual arrangements with such issuers. Moving eligibility determinations to a web-based entity's site risks insurer and agent special interests impacting choice decisions.

If HHS does allow web brokers to submit alternative application flows to HHS for approval, HHS should maintain the FFE's role in determining eligibility, and ensure certain groups are not discriminated against and that all consumers receive comprehensive and accurate information. This approval process should be completed far enough in advance of open enrollment to allow adequate time for website development. Allowing other legitimate platforms to exist in the market can foster continued learning and public-private collaboration to improve the application and shopping experience for consumers. For example, some web brokers have successfully streamlined the application to eliminate redundancy that exists in the FFE application. But HHS must maintain oversight and enforcement authority to ensure these alternate flows are accurate and provide consumers with an efficient and correct eligibility determination.

Additionally, we strongly support HHS' proposal to require specific branding and/or wording that indicates a web broker has marketplace approval to do end-to-end enrollment. This will help consumers, and organizations and individuals who assist consumers, identify trusted enrollment websites.

Further, we want to caution that if web brokers use an alternative application flow or even a backdoor portal to healthcare.gov, HHS must ensure that brokers provide consumers with sufficient information about their application to ensure easy transfers between a broker's website and healthcare.gov. Some consumers may use a web broker for initial enrollment but during the year may need to make a life change or seek to re-enroll independently on healthcare.gov or using another broker or assister. We have heard of consumers who used brokers to enroll in 2015 coverage but never received their application number or understood they could create an account at healthcare.gov to access their information. They had significant difficulties trying to re-enroll for 2016 without this information since the broker's portal did not create an application for the consumer on healthcare.gov that the consumer could access. Thus we strongly recommend that HHS require all brokers, web and in-person, to provide consumers with an application number that can be used at healthcare.gov or with the FFE Call Center to look up an application and make any needed changes. Especially if a web broker uses an alternate application flow, we urge HHS to require this alternate flow to provide an application number or some other identification method that a consumer who directly contacts healthcare.gov after enrollment will be able to make changes and re-enroll in the future easily and without having to completely start the process from scratch by creating a healthcare.gov account or always have to return to the same web broker. This is also important if the web broker is not available to a consumer for future enrollment periods.

b. HHS Oversight and Display Requirements for Web Brokers

We support HHS' proposal to increase monitoring and oversight of all web brokers to ensure all consumers are being well served. HHS should confirm that all web brokers are adhering to approved application questions and flows, providing accurate eligibility assessments (including for Medicaid and CHIP, complex household like those with more than two adults, with mixed immigration status, and American Indians/Alaska Natives) and appropriate consumer support, displaying all plan information fully and accurately, and complying with privacy and security standards via regular audits. We recommend that HHS conduct regular audits of all authorized web brokers throughout each open enrollment period to ensure that these entities are following FFE requirements. These audits should be conducted equitably across all web brokers. If violations are identified during an audit, HHS should work with the web broker on a plan for the broker to come into compliance.

We are certainly concerned about monitoring and oversight if web-based entities are permitted to enroll consumers directly. It will be both time consuming and costly to sufficiently monitor web-based entity performance to ensure that consumers are provided an experience that does not deviate from what is available on the Exchange website. We urge HHS to gather and analyze comprehensive data on the consumer experience to date with web-based entities, making such data and analysis public, and subjecting it and any resulting specific proposal to public comment before taking any action on this proposal. If this proposal goes forward, we strongly urge HHS to include regulatory provisions that require strong consumer protections, along with robust audits, monitoring, and enforcement authority to Exchanges in order to ensure consumers are

able to make the most informed choices, their privacy is protected, and they do not face discrimination or adverse selection.

Our concerns about this proposal are compounded regarding the potential impact of direct consumer enrollment through web-based entities on those who are eligible for Medicaid and CHIP. What would happen to consumers who start the application process through a web-based entity and are told they are eligible for Medicaid or CHIP? Because issuers do not pay web-based entities to enroll people into Medicaid and CHIP, would those consumers be abandoned to navigate their own way through the FFM or State-based Exchange? This would create a significant hurdle for a substantial portion of the low-income population eligible for Medicaid/CHIP and differential treatment for such applicants. Such a complex, lengthy process might dissuade some of those most in need of coverage from completing the process. We urge HHS to carefully consider the particular implications of direct web-based entity enrollment on this population.

We appreciate that the Department has specified that web-based entities be required to use the FFE single streamlined application, the same language for application questions, and the same sequence of information to determine eligibility. We strongly believe this consistency is important for consumer understanding. But we believe the rules should also explicitly ensure that web-based entities are required to:

- Provide consumers with the ability to anonymously explore or search the website to learn more about the health coverage programs and plans available to them, including insurance affordability programs. Consumers should be able to explore the website without being required or prompted to share information beyond the minimum information needed to generate a premium: ZIP code, or age for each family member seeking coverage.
- Prior to requesting personal information, notify consumers how individually identifiable information is collected, used and disclosed.
- Not use confusing, look-alike data elements such as “customer reviews,” “quality ratings” or “best seller” designations that are less robust than or contradictory to similar items found on the [healthcare.gov](https://www.healthcare.gov) (such as standardized quality ratings).
- Post a clear and prominent statement on every page that indicates to consumers that they may go to the Exchange’s website at any time to complete enrollment.
- Provide notice that the web-based entity, including any certified agents using the web-based entity, are paid for enrollment by carriers. Agents and brokers owe a fiduciary duty *solely* to the carrier, not to the consumer; consumers are often not aware of this. It important that consumers understand the compensation scheme in light of the fiduciary relationships.
- At a minimum, commit to the same nondiscrimination requirements as the Exchange, including access for Limited English-Proficient consumers and persons with disabilities. The web-based entity should be required to have a Spanish language web site and telephone assistance in all languages. They should be held to the same standard, thus making available their websites and customer service in English and Spanish and telephone assistance in any language, including American Sign Language. At a minimum, applications should

be provided in alternative formats including Braille and large print font for those with visual impairments.

- Prohibit web-based entities from gathering or storing data beyond that necessary for healthcare.gov, state-based Exchanges, and Medicaid eligibility and enrollment via “cookies” or other tracking tools. Also, bar web-based entities from storing or using information gathered from consumers in the application process for marketing other products.

Given that the proposal in the Preamble means that consumers will never to interface with an Exchange website upon application and enrollment, we ask that the following important consumer protections be applied to web-based entities:

- Require web-based entities to display all qualified health plan (QHP) information and data provided by the Exchange, *in a manner consistent with the display at the Exchange*, such that a consumer is able to access all of the same information as at the Exchange.
- Require prior approval before web-based entities use any display features or tools that vary from those available on the Exchange website.
- Require that web-based entity sites prominently display all consumer choice tools that the Exchange website makes available, such as the required premium and cost-sharing calculator or the ability to filter by whether a particular physician is in a plan’s network. In particular, it must be made clear to consumers which plans will provide them the most affordability assistance. Consumers must be able to view the premiums and cost-sharing amounts for each plan based on what their individual costs would be (after their premium and cost-sharing assistance is accounted for).
- Require that web-based entity sites use the same display order as the Exchange website, and use the default sort order for QHP choices that is the same default sort order for the Exchange website and allow consumers to easily alter the sort order by the same options available at the Exchange. When the consumer hides or filters out choices, there must be a clear indicator that not all choices are currently displayed.
- Clearly delineate between plans that are on-marketplace versus off-marketplace, along with an explanation of the benefits of marketplace coverage (e.g., financial help now or later when filing taxes if circumstances change).
- Show all marketplace plans regardless of the web broker’s relationship with issuer. At minimum the following should be required for every marketplace plan:
 - basic premium and cost-sharing information;
 - links to the summary of benefits and coverage; and
 - an explanation and directions on how to purchase products not sold by the web broker

c. *New Standards for Termination of Agent and Broker Agreements and Standards of Conduct for Agents and Brokers*

We share HHS' interest in ensuring there are robust consumer protections in the marketplaces to prevent and mitigate harm to consumers from any bad actors, including those who are agents and brokers. We support the proposed changes in oversight of agents and brokers in the FFE; specifically, we support instituting new standards of conduct for agents and brokers that align with requirements for other assisters, including requiring all agents/brokers to provide consumers correct and full information, obtain consent before assisting a consumer, and protect PII, as well as refrain from misleading or discriminatory marketing, as outline in paragraph § 155.220(j).

§ 155.225 – Standards Applicable to Certified Application Counselors

a. § 155.225(b)(1) Reporting Requirements

We support codifying certified application counselor organizations' duties regarding performance data collection and reporting to an Exchange. We agree that tracking performance enhances an Exchange's ability to monitor certified application counselor organization's work. Performance data also provides valuable information about scope of current enrollment efforts that can in turn inform the Exchange's targeted outreach and identify needs.

We are concerned, however, about the scope and frequency of the FFE's proposed reporting requirements. As the preamble recognizes, certified application counselors (CACs) are important stakeholders and any additional burden on them should be minimized.¹⁰ Specifically, CACs' engagement in enrollment is more dynamic than navigators'. For example, CACs are more likely to be volunteers or have primary or significant job duties unrelated to enrollment. Some CACs and certified application counselor organizations may serve consumers primarily during open enrollment and have very limited capacity to fulfill enrollment-related duties outside of open enrollment. Therefore, we recommend considering alternative methods of collecting performance data to further minimize the reporting burden on certified application counselor organizations. In particular, we recommend using existing data collection platforms to avoid duplicative efforts. For example, consider tracking the number of CACs by requiring CACs to enter an ID number when completing required training curriculum, similar to what navigators do when completing the training. Additionally, explore whether the information CACs provide to the FFE when helping consumers apply can provide some of the performance data sought.

Regarding the scope of data the FFE proposes to collect, we strongly urge the FFE to *require* organizations to report as few data categories as necessary and to clearly define each category to ensure that organizations can easily and consistently report data. We support requiring organizations to report the number of individuals who have been certified by the organization and further recommend that organizations report the

¹⁰ *Id.* at 80 Fed. Reg. 75,528.

number of *currently* certified CACs. That is, we believe it would be useful to know the CACs who are actually available and certified to assist consumers.

We also recommend amending the FFE's proposed performance reporting categories to clarify how they differ. In particular, the difference between "selecting a QHP" and "enrolling in a QHP" is unclear. To clarify that "selecting" is about evaluating and choosing at QHP, we suggest describing QHP selection as "evaluating QHP options." Regarding reporting frequency, we think that monthly is appropriate during open enrollment. However, we recommend requiring less frequent reporting outside of open enrollment to further minimize the burden on organizations. Recognizing that some organizations' enrollment activities and capacity are significantly reduced outside of open enrollment, the likelihood of receiving performance data each month is similarly reduced. We believe that requiring organizations to report performance data each month throughout and the month following open enrollment and every other month (or perhaps even quarterly) during remaining months strikes the right balance between minimized burden and effective monitoring.

We are also concerned about the proposal to allow Exchanges to establish reporting standards without any further guidance. We share your recognition that Exchanges should have flexibility to establish standards appropriate to their needs, but we believe that additional guidance is necessary to discourage Exchanges from overburdening their certified application counselor organizations. Additionally, from a compliance perspective, certified application counselor organizations that operate under the umbrella of national organizations would benefit from standardized reporting requirements across Exchanges. Therefore, we recommend establishing limits on both the scope and frequency of performance data reporting requirements in all Exchanges. The limit could be that an Exchange cannot require organizations to report more data to submit reports more frequently than the FFE. As the proposed language for what FFE organizations must report does in the phrase "at a minimum," the rule should similarly clarify that a non-FFE Exchange may allow or request more data or more frequent reports, but may not *require* either.

RECOMMENDATION: We recommend amending § 155.225(b)(1)(iii) as follows:

Provides data and information to the Exchange regarding the number and performance of its certified application counselors and regarding the consumer assistance provided by its certified application counselors, upon request, in the form and manner specified by the Exchange. ***An Exchange may permit but shall not require an organization to provide more data or more frequent reports than the Federally-facilitated exchange requires as outlined herein.*** Beginning in January 2017, in a Federally-facilitated Exchange, organizations designated by the Exchange must submit monthly reports that include, at a minimum, data regarding the number of individuals who ~~have been~~ ***are currently*** certified by the organization; the total number of consumers who received ***pre-application***, application and enrollment assistance from the organization; and of that number, the number of consumers who received

assistance in applying for and ~~selecting a~~ **evaluating** QHP **options**, enrolling in a QHP, or applying for Medicaid or CHIP.

Furthermore, we recommend clarifying these performance data categories through instructions. For navigator grantees, common points of confusion that we have heard are (1) how to capture assistance such as answering questions when the assister does not also provide direct application or enrollment assistance, (2) whether to count each member of a consumer's household separately, and (3) whether to report multiple points of assistance to the same consumer across reporting categories. For example, if an assister answers a consumer's questions at an outreach event and then later meets with the same consumer and helps her apply for and enroll her family in various programs (i.e., QHPs and Medicaid), how many data points should the assister record? We recognize that HHS has responded to these concerns by amending the specific data collection requirements in the Information Collection Request under the Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Exchanges¹¹ and encourage HHS to proactively take similar steps to further clarify and simplify these proposed certified application counselor organization reporting requirements.

b. § 155.225(g)(4) Gifts and Promotional Items

We support amending § 155.225(g)(4) to simplify the rule restricting certified application counselors from providing certain gifts and promotional items to an applicant or potential enrollee. We agree that this rule for certified application counselors should be consistent with the proposed amendments to § 155.210(d)(6) for the same reasons discussed above.

§ 155.260 – Privacy and Security of Personally Identifiable Information

As HHS proposes changing the cross-reference, it would likely be more streamlined to directly cross-reference 42 C.F.R. § 435.4 rather than 45 C.F.R. § 155.300 which only cross-references directly to 42 C.F.R. § 435.4.

§ 155.280 – Oversight and Monitoring of Privacy and Security Requirements

We support the extension of this section to also apply to SBE-FPs. Rather than merely permit HHS to oversee and monitor SBE-FPs, we would recommend making this a requirement of HHS. Since SBE-FPs necessarily are conducting some operations themselves (as outlined in § 155.200), it is essential that HHS ensure the SBE-FPs are maintaining the same strong privacy and security requirements so that consumers in those states are not at any risk of disclosure of personal information.

¹¹ See Dep't of Health & Human Servs., Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 75521 n.23 (proposed Dec. 2, 2015).

§ 155.302 – Options for Conducting Eligibility Determinations

We support the proposal to allow SBE-FPs to rely on HHS to carry out eligibility determinations and other requirements within Subpart D through a federal platform agreement. One concern we have, however, is to ensure the seamless interoperability between the federal platform and the state's Medicaid (and CHIP) programs. Thus, before a state can rely on HHS for eligibility determinations, HHS should require it to show full functionality to accurately and timely accept and process applications from the FFE that must be transferred to the SBE-FP. Currently, many FFE states still have difficulties processing account transfers from the FFE for Medicaid and CHIP applications. We would not want to see this replicated by an SBE-FP newly coming on to use the federal platform. Prior to executing a platform agreement with an SBE-FP, HHS should ensure the functionality of the SBE-FPs system to accept, store, transfer, and timely process Medicaid and CHIP applications without any delays or backlogs.

§ 155.310 – Eligibility Process

We understand the rationale for notifying employers if their employee(s) have been determined eligible for Exchange financial assistance due to the potential tax liability for the employer. We are concerned, however, that some employers may use this information against employees and subject them to retaliation, discipline or termination.

This is especially important because we have identified systems issues that have allowed many consumers who should not be eligible for APTCs to receive them. Thus, further subjecting these consumers to notification of their employers could lead to facing potential consequences at work – because of the tax implications for the employer – when getting APTCs was not their fault. As an example, we have received many reports from assisters across the country about consumers receiving APTCs who are not eligible due to the family glitch or offers of affordable employer-sponsored insurance (ESI). Yet, due to functionality issues with healthcare.gov, some consumers who are asked about ESI are not asked questions about its affordability and thus are inappropriately determined eligible for APTCs. Further, the Call Center has provided erroneous information as well about the family glitch and ESI coverage and, when completing telephonic applications, has allowed some ineligible consumers to receive APTCs. We can provide more direct information about these issues if helpful. It is difficult to quantify the scope of this problem but we do not believe any consumer should face repercussions from an employer due to erroneous determinations or information provided by healthcare.gov and the FFE Call Center.

We thus strongly recommend two additions to this section:

1. A specific requirement that employers not use this information to discriminate, discipline or terminate against any employee (or the employee's family);
2. Notice is also provided to the employee along with information that the employer may not discriminate.

We do agree that if an employee has applied and been determined eligible for Exchange coverage but has not enrolled that HHS should not send a notice to the employer.

§ 155.320 – Verification process related to eligibility for insurance affordability programs

We appreciate the recognition that many consumers have difficulty projecting their annual income as it may fluctuate during the year due to a variety of factors. We support the adoption of an alternate threshold and agree that it cannot be less than 10% since it would not be a reasonable standard.

§ 155.335 – Enrollment in Qualified Health Plans

a. § 155.335(j) New Re-enrollment Hierarchy for Silver-level QHP Enrollees

We commend HHS for continuing to improve the re-enrollment process to better serve consumers' interests. We strongly support creating a new re-enrollment hierarchy for all enrollees in a silver-level QHP that is no longer available for re-enrollment. As the preamble recognizes, preventing disruptions in cost-sharing reductions is important and we believe it should be a primary goal of the re-enrollment process.¹² We think that consumers enrolled in silver-level QHPs are more likely than bronze-level enrollees to have chosen their QHP based on factors other than premium such as cost-sharing. For that reason, silver-level QHP enrollees, especially those eligible for cost-sharing reductions, expect to be reenrolled in a silver-level QHP. We agree that the proposed hierarchy is both an operationally efficient way to maintain continuity for enrollees eligible for cost-sharing reductions and likely to be more consumer protective. Therefore we support amending § 155.335(j)(1) as proposed.

With regard to determining which available plan is most similar to the enrollee's current plan, we recommend considering continuity of plan type (HMO v. PPO), providers (not issuers), and cost (including cost-sharing). Please see our discussion of these factors below in our recommended default hierarchy.

To maintain the goal of minimizing potential enrollment disruptions, we support permitting enrollees to be automatically re-enrolled into a plan not available through the Exchange so long as that is the last option in the hierarchy. We encourage HHS to continue to improve re-enrollment notices, in particular issuer notices, to better inform consumers who will be re-enrolled outside of the Exchange that they can return to the Exchange to select a plan and potentially receive for cost sharing reductions.

We recognize a default process for auto-reenrolling consumers is necessary as some consumers will not actively return to the Exchange to make plan choices during open enrollment. We also agree that the current default re-enrollment hierarchy sometimes encourages consumers to remain in plans that are significantly more expensive than the

¹² *Id.* at 80 Fed. Reg. 75,531.

lowest-cost plans available. Experience during the third open enrollment period has continued to show that affordability is many consumers' primary concern. We have heard that some consumers prefer to re-enroll in their same QHP and exercise their option to select a new QHP only because they feel like the re-enrollment option offered is unaffordable. In addition, when consumers are notified that their premiums will increase, some are discouraged from re-enrolling in part because they do not realize more affordable options may be available. However, we have also observed increased consumer recognition of the importance of continuity of providers and covered services and cost-sharing structure. Thus, it is vitally important that the reenrollment methodology continue to prioritize and balance affordability and continuity of coverage, cost-sharing, and providers, while encouraging consumers to play an active role in regularly evaluating and choosing their plan.

In light of these priorities, we renew our support for a re-enrollment approach that includes a new default hierarchy based on balancing (described below) as well as an option for sophisticated consumers to select their re-enrollment hierarchy, with the exception of silver-level enrollees whose default hierarchy should be governed by the newly proposed § 155.355(j)(1)(iii)(A).

We also recommend that HHS explore other means of helping and encouraging renewing consumers to *actively* re-enroll in a plan that best meets their needs and budget. For example, HHS could improve the HealthCare.gov window-shopping and plan-compare tools 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 the Exchange or issuers provided such information.

I. Recommended Default Approach

It is important to note that consumers rarely prioritize continuity of issuer. Consumers care about their providers, coverage of services they use, and cost-sharing 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, cost-sharing structure, 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 QHP if the plan's premium does not increase more than 10%.

2. If current QHP's premium increases more than 10%, consumer is enrolled into the lowest-cost QHP of the same metal level that includes the consumer's PCP, 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 no QHPs within 20% of the current plan that include the individual's PCP are available, the consumer is enrolled in the lowest-cost plan of the same metal level (including plans that do not include the primary care provider).

Of course, the Exchange would only implement the above re-enrollment hierarchy if a consumer did not actively choose a QHP after the normal re-enrollment notice process. We note that, while plan premium is an important indicator of cost, it is not the only indicator and believe that considering cost-sharing and other costs consumers absorb is equally important. Therefore, the above hierarchy would ideally factor in these other costs when evaluating affordability by considering individual cost-sharing elements such as deductibles. Finally, we note that the above hierarchy would rely on random assignments when two or more plans were tied as the lowest-cost plan(s) to spread enrollees across plans.

II. Offering Choice of Re-enrollment Hierarchy

Our first recommendation is to adopt a new default hierarchy as proposed above. Additionally, we support a re-enrollment hierarchy choice for most consumers, assuming HHS has a simple way to implement the choice that will not overly burden or confuse consumers. We recognize the likely significant overlap between consumers who would opt in to an alternative hierarchy and those who would actively re-enroll, as more sophisticated consumers who would opt in are probably more proactive as well. Nonetheless, allowing consumers to choose to heavily weight continuity of QHP, plan type (HMO v. PPO), providers (not issuers), or cost (including cost-sharing) in their re-enrollment will reduce administrative hassle for consumers and the system as a whole. However, if HHS offers a choice of hierarchies, we think silver-level plan enrollees eligible for cost-sharing reductions should not be allowed to choose an alternative hierarchy because the default re-enrollment hierarchy under proposed § 155.335(j)(1)(iii)(A) prioritizes the important goal of cost-sharing reduction continuity. Allowing these consumers to select an alternative hierarchy could lead to unintended disruptions in cost-sharing reduction eligibility and work against the proposed rule's goal.

As discussed above, we believe most consumers prefer to stay in their same plan and are likely to return to the Exchange to select a new QHP if they do not like their current coverage. Therefore, we recommend that the consumer's choice of alternative hierarchy be triggered if their current QHP's premium increases more than 10%. A lower threshold would likely decrease continuity for a significant number of consumers, and, as noted above, we think most consumers are willing to absorb modest increases in price to maintain current coverage. In the future, it may be worth considering indexing this threshold to the average QHP premium increase. If a consumer's current QHP premium

increases by more than average, the Exchange would use the consumer's selected alternative hierarchy to enroll them in another plan.

We recognize that at the time of initial application many consumers will know whether they have pressing provider or financial needs which will inform their re-enrollment priorities. However, we also recognize that many consumers do not understand their needs or how a plan will meet their needs until after they enroll and use their coverage. Therefore, we recommend that the Exchange ask consumers to reevaluate their re-enrollment hierarchy choice each open enrollment period and each time they report changes in circumstances to the Exchange. We also think asking consumers to reevaluate their choice provides additional and continuing opportunity to notify consumers that opting in to an alternative hierarchy prioritizing premium cost may result in other significant changes to provider networks and cost-sharing. Regarding implementation timing, we recognize that the re-enrollment process is still new and can continue to be improved in the coming years. However, we also think that consumers are in the best position to adapt to process changes while the whole enrollment process is new. Therefore, we recommend implementing such alternative hierarchy during the 2017 open enrollment period.

III. Re-enrollment Notices

We also recommend that HHS continue to improve the language of notices to enrollees. The 2016 Marketplace Open Enrollment Notices (MOENs) were much improved, but we encourage HHS to continue to provide consumers with more specific information. In particular, we recommend that MOENs remind consumers who opted into a re-enrollment hierarchy at enrollment of their choice.

Additionally, we believe that consumers whose APTCs and CSRs cannot be re-determined automatically need more information about the circumstances preventing the re-determination and how to resolve these issues. We recognize important privacy policies constrain play, but believe that opportunities exist to improve the MOENs' effectiveness without compromising privacy.

Furthermore, we believe the 2016 issuer notices failed to effectively convey the opportunity and importance of returning to the Exchange to make plan choices and the consequences of not doing so. For 2017, we recommend requiring issuers to explain to silver-plan enrollees who are eligible for cost-sharing reductions that they are being renewed in a silver-level plan to avoid disruption in their cost-sharing reductions. We also note that some consumers received these notices after open enrollment began and encourage HHS to ensure issuers finalize QHPs and issue notices in advance of open enrollment. We also encourage increased coordination in terms of timing and coordination between MOENs and issuer renewal notices as the multiple notices continue to cause consumers confusion.

§ 155.400 – Enrollment of qualified individuals into QHPs

We support the requirement that SBE-FPs must rely on HHS to implement the functions with regard to eligibility and enrollment through the federal platform agreement. As we mentioned above (see comments to § 155.302), however, we strongly recommend that HHS obtain assurances and commitments that an SBE-FP has the processes in place to effectuate FFE eligibility and enrollment determinations.

We also strongly support flexibility to accept less than full payment of amounts due to avoid termination. We recommend HHS go further than the proposed rule for consumers who may not be paying their full payments due to data matching issues (DMI) or inconsistencies. Due to the current HHS interpretation of the appeals rules, consumers with a DMI must wait until the termination of the entire inconsistency period (90 or 95 days) before they can appeal either having been put into an inconsistency period in the first place or having coverage terminated or APTCs reduced at the end of an inconsistency period if the DMI is not resolved. We have received significant numbers of complaints from consumers who are stymied by the process to resolve their inconsistencies. This is due to systems issues, faulty notices, and a lack of receipt of notices. All of these issues are intertwined in such a way that many consumers who have DMIs believe they have sent in sufficient documents to resolve their DMI only to find out after the end of the DMI reasonable opportunity period that they actually did not resolve the DMI and instead have had their APTCs reduced or terminated.

The impact of the faulty DMI resolution process has left many consumers responsible for paying the full premiums to their issuer after the end of the inconsistency period and during the appeal process, which often takes longer than 90 days (or longer than 30 days for an expedited appeal). For consumers determined initially eligible for APTCs, this can create an extreme financial hardship and puts these consumers in a bind of maintaining coverage with full premiums versus losing coverage and possibly suffering financial hardship if they incur medical expenses or an individual responsibility payment if coverage lapses for more than 3 months. While an appeal resolution can provide retroactive coverage, this is of little comfort to consumers suffering financial burdens during the appeal period. And given the number of consumers appealing from DMI issues, the appeals process has also taken longer for many consumers than expected, extending the time period for which they have to pay full premiums to maintain coverage or remain uninsured and at risk of incurring significant medical costs if an emergency arises or they have an ongoing or chronic condition needing treatment.

We thus suggest that issuers be required to accept the consumer's portion of the premium as full payment and abide by the 3-month grace period requirement (rather than shorten it to 30 days if a consumer does not have APTCs) if a consumer has a pending appeal. If requested by an issuer, the consumer could provide an appeal number to the issuer to document the process so that the issuer could terminate consumers who have chosen not to contest reduction/termination of APTCs due to a data matching issue. Extending the grace period and requiring payment of only the consumer's share of premiums would protect the consumer from financial burdens during the appeal and also prevent the insurer from having to terminate a potentially still

eligible consumer and then reenroll that consumer -- and process retroactivity enrollment and claims payments -- after an appeal is resolved. We would suggest that the FFM continue payment of APTCs to the issuer during the appeal resolution process if the consumer's appeal is accepted. Due to the fact that resolving DMIs and appealing wrongly terminated APTCs/coverage due to an inconsistency still have significant barriers due to systems issues with the FFM, the burden should not be shouldered by the consumer to pay full premiums or risk termination with a shorter grace period for lapses by the FFM. Indeed, it is because the consumer has been put at risk of losing coverage due to systems and notice deficiencies that the burden should be on the FFM to compensate the consumer and issuer rather than force the consumer to bear the full brunt of full-cost premiums.

§ 155.410 – Initial and annual open enrollment periods

We certainly support as long of an open enrollment period as possible to ensure all eligible consumers are able to learn about their options and enroll. We strongly support continuing the portion of the open enrollment period occurring after January 1. 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.

As we have noted before, late November and December are heavy holiday periods, and deadlines in those periods may be difficult for consumers to track, even if they track employers' open enrollment and Medicare open enrollment. We thus recommend that the annual open enrollment period continue to end on January 31.

Regarding the start of open enrollment, we support the suggestion to move the date earlier (as long as the ending date is not moved 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 would support an earlier start to open enrollment, such as October 15.

§ 155.420 – Special enrollment periods

We are concerned about the proposal to allow cancellation or retroactive termination of an enrollee's enrollment if determined a consumer's enrollment was due to fraudulent activity. While we recognize HHS may be hearing anecdotal evidence that SEPs may be subject to abuse, we do not believe HHS should act without concrete data of a widespread problem. While we recognize isolated incidents of abuse of SEPs may occur, we believe the vast majority of consumers and assisters are using SEPs validly and should not suddenly be subject to evaluation of fraud for every SEP. Many consumers are still learning about the ACA and FFM and legitimately have used SEPs to gain coverage when life changes occur. Further, due to the systems issues outlined

above about DMIs as well as consumers sometimes being determined eligible for APTCs despite being in the family glitch or having affordable insurance, it should not be a responsibility of the consumer to suddenly meet a high standard of proof to obtain an SEP or possibly suffer cancellation or retroactive termination. Much of the responsibility rests with the processes for granting SEPs and thus evaluating the process of approving SEPs and finding ways to more effectively evaluate these requests at the "front end" would provide a better opportunity for reducing the number of SEPs granted to ineligible consumers rather than shifting the burden of proof to a consumer who has enrolled and may later face cancellation or retroactive termination. Thus, since the FFE grants the SEPs, it should be the responsibility of the FFE to correctly grant them and consumers should not be responsible to prove their eligibility after-the-fact, particularly when it would be next to impossible to look behind a consumer's application to identify why an SEP would have been granted or to identify fraud. Unless the FFE could document intentional fraud, the benefit of the doubt should remain with the consumer in potential cases of accidental misrepresentation or lack of understanding of eligibility for an SEP.

§ 155.430 – Termination of exchange enrollment or coverage

We support allowing a consumer to terminate coverage, including retroactive termination, due to technical error or fraudulent enrollment. As an example of the importance of this provision, we have heard a number of incidents during OE3 where a consumer enrolled by an agent or broker for 2015 coverage was reenrolled in 2016 coverage without the consumer's permission or even contact by the agent/broker.

§ 155.505 – General Eligibility Appeals

a. Appeals related to Inconsistencies

We are concerned that current HHS interpretation of the grounds for filing an appeal does not include an eligibility determination if that eligibility determination notice (EDN) includes an inconsistency, even if other final determinations are made. Our understanding is that HHS differentiates between a "final" eligibility determination and an "interim" (or temporary) eligibility determination and that an interim determination is not appealable. That is, if a consumer has a data matching issue (or inconsistency), HHS has effectively granted the consumer only temporary eligibility until the inconsistency is resolved. While we understand that the consumer may have to take additional steps to maintain coverage, we strongly believe that a consumer must be able to appeal an interim decision both to contest the existence of an inconsistency in the first place or the evaluation of documentation submitted to resolve the inconsistency but also to appeal other determinations that may be final but included in an interim eligibility determination, such as a denial of Medicaid/CHIP, amount of APTCs (e.g. if an individual has a citizenship inconsistency which would not impact the amount of APTCs granted), or other determinations. A consumer should not have to wait at least 90 days until the termination of the inconsistency period to appeal both the inconsistency itself and other determinations.

We do not believe HHS' interpretation of its regulations agrees with statutory interpretation. Section 1411 of the ACA (codified at 42 U.S.C. § 18081) provides that the Secretary or other federal officers:

hears and makes decisions with respect to appeals of any **determination** under subsection (e) and redetermines eligibility on a periodic basis in appropriate circumstances.¹³

Subsection (e) specifically includes actions relating to verification including inconsistencies (see (e)(2), (3), & (4)) and does not differentiate between an interim or final determination. Congressional intent illustrates a consumer's ability to appeal an inconsistency but current HHS interpretation does not and thus HHS should change its interpretation.

Indeed, the current version of § 155.505 includes the ability to appeal an "initial determination" of eligibility. But in practice, HHS' Office of Hearings and Inquiries has not acted on appeals filed if the EDN includes an inconsistency. The regulations, however, do not differentiate between an interim or final EDN and only mention an "initial" determination. The section further says a consumer can appeal an initial determination of APTCs and CSRs.

A consumer with an inconsistency has a determination of eligibility pending further documentation and rights attach to the consumer's receipt of insurance during the inconsistency period that must be upheld. By not allowing the consumer to appeal, for example, HHS' determination if certain documents submitted to resolve an inconsistency were acceptable, HHS necessarily puts the consumer's rights, and sometimes health, at risk. That is, by forcing the consumer to wait until the inconsistency period ends, the consumer is forced to pay 100% of the premiums during the pendency of an appeal if she wants to maintain coverage. If a consumer was receiving APTCs under the initial determination, this would present a financial hardship to the consumer, especially since many appeals are taking longer than expected. And consumers with ongoing or chronic health needs may be unable to pay 100% of the premiums and suffer adverse health consequences by losing their insurance. If a consumer could appeal, for example, HHS' rejection of submitted documents to resolve an inconsistency during the inconsistency process, the consumer could have the ability to "cure" the inconsistency during the 90 days and not face having to pay 100% of the premium or forego coverage after the inconsistency period during a formal appeal. We recognize that systems and notices issues have prevented many consumers from resolving their inconsistencies during the 90 or 95 day inconsistency period. If consumers had the ability to effectively communicate with those tasked with reviewing submitted documents and if notices effectively communicated deficiencies in what consumers provided so they could send additional information, many consumers likely would be able to resolve their inconsistencies during the period and not have to file appeals. Thus, setting up an effective communications (not appeal) process during the 90/95 day inconsistency period would likely cure the need for many post-inconsistency

¹³ 42 U.S.C. § 18081(f) (emphasis added).

period appeals. That is, consumers need to be able to call the unit tasked with reviewing inconsistency cases, similar to how consumers can now call the Appeals Center once an appeal is filed. While the Call Center has limited information about whether documents have been submitted or are pending review, the Call Center is unable to instruct consumers directly about whether additional documents are needed or the specificity of what may be missing. Having this direct communication would likely alleviate the need for many inconsistency terminations/reductions as well as many appeals. Anecdotal information we have received relays that many of the alleged inconsistencies are ultimately solved in the appeals process. As a procedural matter, these cases should likely never have gotten to the appeals stage but the inability of consumers to effectively understand what is missing and to communicate directly with those evaluating documents sent to resolve inconsistencies has forced many consumers to rely on the appeals process for ultimate resolution.

But while many of these cases should and could likely be resolved prior to appeals, some consumers may still have a legitimate reason to appeal during the inconsistency period and should not be forced to wait until the end of the inconsistency period to appeal and bear financial hardship of paying 100% of the premiums or forego coverage. We thus recommend that HHS amend § 155.505 to specifically include appealing an inconsistency during the inconsistency resolution period. If HHS believes other regulatory sections should also be amended to comport with this decision, we would support those revisions as well.

If HHS does not agree with our interpretation, we would recommend that, at a minimum, HHS allow consumers to appeal final determinations even if the consumer has an inconsistency. That is, a consumer who is denied Medicaid/CHIP, determined eligible for APTCs/CSRs or has other final determinations made should be able to appeal those determinations before the inconsistency clock on an unrelated issue runs out. We also strongly recommend that HHS establish a direct communication link for consumers to communicate with the staff tasked with reviewing consumer's documents to resolve inconsistencies to help fix the problem before it gets to the appeals stage.

b. Other Appeals Issues

We support the addition of paragraph (b)(1)(iii) to clarify that consumers have the right to appeal their decisions of eligibility for a special enrollment period. There has been significant confusion, among both consumers and assisters, over what decisions can be appealed so any additional clarification is much appreciated.

We also support the clarification that consumers have the right to appeal decisions made by the state exchange. We recommend that HHS sets certain standards for state exchanges making this right clear to the appellant after the state decision is made. Further, either through regulation or guidance, HHS should provide clear procedures and timelines for this appeal process so that consumers and their legal representatives can better determine whether it is in their interest to pursue this second appeal rather than judicial review.

RECOMMENDATION: Ensure that state exchange appeals entities are clearly communicating the right to appeal to HHS to consumers and under what circumstances a consumer may want to pursue such an appeal. Provide more information about the process and timelines for hearing appeals from a state exchange and for the final decision.

§ 155.510 – Appeals Coordination

As a workaround or interim measure, we support allowing the appeals entity to request information from an appellant that the appellant has already provided. We recognize the current technological and systems limitations that hinder transfer of information from healthcare.gov and its eligibility contractor to the appeals entity. While as a guiding principle, consumers should not bear the responsibility to provide documents or information multiple times, until healthcare.gov is upgraded to allow more seamless transfers of documents and information, we acknowledge what we hope is a time-limited need to request duplicates of some information.

However, we request additional protections for the consumer when it comes to the appeals agency requesting information that has already been submitted in paragraph (a)(1). We recommend that the language be added that institutes considerations when consumers are unable to re-submit documentation in a timely manner. Currently, § 155.545(b) provides for a hearing decision within 90 days, as administratively feasible. It would be helpful to add some standards for how quickly the appeals agency must request further documentation from the consumer, how soon documentation must be provided to receive a decision within 90 days, and that the timeline can be extended if the consumer requests more time to provide documentation. We also recommend that the appeals agency be held to a timeliness standard when requesting the re-submission of materials. The consumer should not be subject to long processing delays when submitted materials they have already produced at an earlier date. Where possible, the appeals agency should accept consumers' attestations to avoid such delays and thus all submissions to the appeals agency should be processed expeditiously. We have heard from both consumers and assisters that the appeals process can be lengthy and arduous. We encourage instituting this work around with significant protections so that the burden does not fall onto the consumer and the request does not result in lengthier processes.

Finally, we strongly suggest HHS revisit this requirement in the 2018 Benefits & Payment Parameters NPRM and eliminate this new requirement if the systems issues have been solved and that documents and information submitted in conjunction with an application are available to the appeals entity. Thus, the burden must not remain on the consumer who potentially could be subject to dismissal of an appeal without providing documentation when it is the limits of the eligibility system that preclude sharing of documents.

§ 155.520 – Appeal Requests

We strongly support the addition to this section allowing a consumer to be notified if an appeal request is invalid due to not being timely submitted as well as allowing the applicant/enrollee the ability to provide a reasonable explanation that the failure to submit was due to exceptional circumstances that should not preclude the appeal.

§ 155.530 – Dismissals

We support the addition to this section to allow an appeal to proceed upon the death of an appellant if the executor, administrator or other duly authorized representative of the estate requests to continue the appeal. We believe this should also be extended to the spouse/partner and parent/guardian of the deceased. While this may have been intended with the inclusion of "other duly authorized representative of the estate" we are concerned that some consumers may not have an "estate" and should not have to go through a legal process to be duly authorized but, due to familiar relationship prior to the deceased's death, can be recognized to stand in the shoes of the deceased for the purposes of an appeal. This may particularly be true if the appeal concerns coverage of a child or incapacitated adult.

As an example of why this provision is important, an individual may appeal a denial or termination of coverage but pass away during the pendency of the appeal. Yet the need for coverage -- especially to cover medical care provided at/close to the time of death -- may indeed be significant. Allowing dismissal of such an appeal may impose a financial hardship on surviving family members who wish to continue the appeal to perhaps obtain retroactive coverage which would cover the medical bills associated with the deceased's death.

§ 155.535 – Informal Resolution and Hearing Requirements

We support the clarification that the informal resolution process applies to both the FFE and to state exchange appeals entities.

We recognize the limited situations in which a formal written notice of the date and time of the hearing may not be feasible to communicate via writing to the consumer. In these situations, however, we believe it is the responsibility of the appeals entity to ensure both the consumer and any authorized representative are duly notified of the hearing date/time. Thus, if the appeals entity should communicate directly with **both** the consumer and authorized representative about a hearing scheduled at an earlier time for which a written notice will not be sent.

§ 155.545 – Appeal Decisions

We recognize the need to standardize the effective dates for SEPs and inclusion of the cross-references noted.

We support the revision of the retroactive coverage date. However, we also recommend HHS allow a third option between the retroactive coverage date and the date the appeal was decided. For some consumers, the appeals process has taken longer than the 90-day expected time period, leaving them without coverage for more than the anticipated 3 months. Some consumers in this situation may have experienced health issues for which retroactive coverage would be helpful but may not be in a financial situation to pay back premiums for more than a limited number of months. Due to the fact that it is the responsibility of the appeals entity to make a timely decision, we believe that consumers whose appeals take longer than 90 days should have an opportunity to select another retroactive coverage date that falls between the initial eligibility determination and the date of appeals decision when such delay is not the fault of the consumer nor in their control to fix. .

§ 155.555 – Employer Appeals Process

We appreciate the recognition in this section that if an employer's appeal may potentially impact an employee's eligibility determination that the employee receives notice and has the opportunity to participate as an interested party in the employer's appeal. The employee has a direct stake in the outcome as the employee may lose FFE coverage and have to enroll in an employer's plan.

Further, as we noted above in our comments to § 155.310, an employer should explicitly be prohibited from taking any retaliatory, disciplinary or termination action against an employee who received FFE coverage, even if the employer prevails on appeal.

We have heard from many consumers who have enrolled in FFE coverage because of the unaffordability of employer coverage or an inability to determine if the employer coverage is affordable or meets minimum essential coverage requirements due to a lack of information provided by the employer. If the employer is appealing a decision about whether it offers coverage that is affordable or meets minimum value, the employee may have relevant information based on what it learned from the employer which may differ from what the employer presents during an appeal.

The proposed rule would provide Exchanges with two alternatives for implementing decisions of employer appeals relative to employees. Currently, the rule requires that Exchanges redetermine eligibility. The proposal provides an alternative to notify the employee of the requirement to report changes, and the preamble states that the FFM will choose the new alternative.

We support the additional requirement in (l)(2) to notify the employee of the requirement to report changes. If the Exchange will redetermine the employee's eligibility based on the employer's successful appeal, it is important to know other changes that may have occurred since the initial eligibility determination; for example, perhaps an individual was eligible for the employer-sponsored coverage of a spouse but has actually obtained a legal separation (which the employer may be unaware of) and is now filing as a single applicant without access to the spouse's coverage. However, we do not support

maintaining (l)(1) and (1)(2) as separate choices. Instead, the process should start with a notice to the employee of the decision on the employer's appeal, including the potential impact of the decision on the employee's eligibility for financial assistance and the requirement to report any changes and the time frame for making such a report. Once the time for reporting changes has expired, the Exchange will can redetermine eligibility taking into account any changes reported by the employee.

§ 155.605 – Eligibility standards for exemptions

a. § 155.605(a)

The proposed regulations appear to leave out a conforming amendment at § 155.605(a). Paragraph (a) should be amended to strike the reference to “paragraph (g) of this section” and adding in its place “paragraph (d) of this section.”

b. § 155.605(d)

NHeLP supports the proposals HHS has included to simplify the process of applying for a hardship exemption and to resolve timing glitches to ensure individuals can obtain hardship exemptions appropriately. Specifically, allowing certain individuals to apply for hardship exemptions through the tax filing process instead of requiring them to go through a separate approval with the Marketplace not only reduces the bureaucratic steps these individuals have to complete, but also eliminates current problems. Today, when an individual becomes aware of the need for an exemption during tax filing season, she can sometimes no longer obtain an exemption from the Marketplace because it is too late to apply. We also support the policy to allow individuals who have an Exchange Certificate Number (ECN) on a continuing basis, such as tribal members, to use the same ECN unless and until they become ineligible.

For other individuals who will still be required to apply for an exemption through the Marketplace, HHS has proposed new time frames. Individuals would have up to three years to apply for a hardship exemption. Successful applications would grant an exemption from the month prior to the start of the hardship through the end of the following calendar year. If the hardship had still not been resolved after that time, an individual could reapply without resubmitting new evidence. We believe that the three-year limit to apply for an exemption is likely too short. The timing and procedures around shared responsibility payments have yet to be sorted out. In this implementation phase, HHS should establish procedures for HHS to grant an exemption (or for IRS to abate a shared-responsibility payment) if it is clear that the person would have qualified for a hardship exemption had they applied within the three-year timeframe. Moreover, HHS should consult with IRS to review and reconsider this timeframe after the timing for IRS to assess and collect the payment has become settled law. We did find the examples HHS laid out in the preamble to be very helpful for understanding how these time frames apply, and recommend adding them to the regulation in the same way the IRS provides examples for tax codes.

We also support the non-comprehensive list HHS has proposed to lay out specific situations that would qualify individuals for a hardship exemption. So long as it is clear that the list is not exhaustive, these situations help simplify the eligibility for exemptions and inform how the Marketplace should apply the catch-all category for hardship exemptions laid out in paragraph (d)(1). We have included a number of suggestions to improve consistency and specificity in the regulatory language. For example, we suggest replacing “are homeless” in subparagraph (i) with “have experienced homelessness” to better match with the tense used in other subparagraphs. We also urge HHS to clearly (and broadly) define the scope of what constitutes “domestic violence” for the purposes of this section in subparagraph (iv). We recommend cross-referencing the definition laid out in IRS’s temporary rules at 26 C.F.R. § 1.36B-2T(b)(2)(iii), which recognizes the various forms and presentations of domestic violence and includes when the abusive individual targets a child or other family member. No matter the circumstances, abuse of any household member creates a climate of fear and intimidation for all individuals in the home and should always be considered an adequate basis for claiming this exemption.

We believe HHS should add several other examples to this list, including situations where circumstances outside individual’s control could prevent them from obtaining or maintaining coverage because they do not qualify for relief from the joint filing requirement, such as:

- individuals with a spouse living abroad who may face administrative, language access, and documentation transport barriers to filing joint tax returns;¹⁴
- individuals with incarcerated spouses;¹⁵
- individuals who reasonably expect to finalize divorce by the end of the year;¹⁶ and
- individuals in long-term separation.¹⁷

¹⁴ For example, a non-resident spouse may need to obtain an individual taxpayer identification number (ITIN) to file federal income taxes.

¹⁵ Administrative difficulties related to incarceration may make it impossible for the spouse to complete the tax returns and have the forms signed by the incarcerated spouse prior to the tax filing deadline.

¹⁶ Acceptable documentation should include a copy of a legal filing initiating divorce or separation, filing for child support, or a restraining order, a statement from the taxpayer, or a letter from an attorney or other representative of the taxpayer.

¹⁷ Under 26 I.R.C. § 7703(a), those with a “decree of separate maintenance” should not be considered married for federal income tax filing purposes. However, not all states provide a “decree of separate maintenance;” the IRS thus looks to state law to determine whether a “decree of separate maintenance” affects marital status for federal income tax filing purposes. *Boyer v. C.I.R.*, 732 F.2d 191, 194 (C.A.D.C., 1984).

RECOMMENDATION: Amend § 155.605(d)(2) as follows:

Examples of events and circumstances for which the Exchange must grant a hardship exemption to an applicant based on paragraph (d)(1) of this section include, ***but are not limited to:***

...

(i) Individuals who are ~~homeless~~ ***have experienced homelessness.***

(iv) Individuals who have experienced domestic violence. ***For the purposes of this section, domestic violence has the same meaning as in 26 C.F.R. § 1.36B-2T(b)(2)(iii).***

...

(vi) Individuals who have experienced a fire, flood or other nature or human-caused disaster that causes ~~substantial~~ ***substantial*** damage to ~~your~~ ***their*** property.

...

(xii) Individuals who are enrolled in Medicaid coverage provided to a pregnant women that is not recognized as government-sponsored MEC under IRS regulations or HHS regulations or guidance.

...

(xv) Individuals with a spouse living abroad who may face administrative, language access, and documentation transport barriers to filing joint tax returns.

(xvi) Individuals with incarcerated spouses.

(xvii) Individuals who reasonably expect to finalize divorce by the end of the year.

(xviii) Individuals in long-term separations for whom a “decree of separate maintenance” is not available.

c. § 155.605(d)(5)

We support HHS’s proposal to remove the requirement that individuals who fall into the coverage gap during one or more months in non-expansion states first obtain a Medicaid eligibility denial to qualify for the exemption at § 155.605(d)(5). This new policy will eliminate substantial administrative burden for states and will provide an avenue for relief to individuals who should rightfully qualify for the exemption but only learn about its availability during tax filing season.

We also recommend extending this exemption to cover individuals who would be Medicaid eligible under the adult Medicaid group in a state that ***has*** expanded Medicaid, but who have been or would be subject to premiums, a waiting period, or a lockout for one or more months according to the terms and conditions of the state’s Medicaid expansion demonstration. A number of states have implemented demonstrations for adult Medicaid expansions to test the effect of charging premiums for coverage, despite clear Medicaid law that prohibits Medicaid premiums on individuals below 150% FPL. Individuals and families who cannot afford these premiums and do not enroll, or who enroll for a time but are then disenrolled for nonpayment, should not be subject to an additional IRS tax penalty for failure to maintain coverage due to these unproven Medicaid experiments. HHS policy already explicitly acknowledges that anyone who

would be eligible for the adult Medicaid group in a state that refuses Medicaid expansion is eligible for a hardship exemption even if that person could actually qualify for APTCs and CSRs through the Marketplace (i.e. has income over 100% FPL). The situation is no different for an individual in a state that *did* expand Medicaid but charges premiums to its Medicaid enrollees.

RECOMMENDATION: Add new paragraph (6) after § 155.605(d)(5) as follows:

(6) Eligible for Medicaid but subject to premiums in a state that expands Medicaid. The Exchange must determine an applicant eligible for an exemption for a calendar year if he or she would be determined eligible for Medicaid and be subject to premiums, a waiting period or a lockout or similar coverage ban for one or more months in a State that implemented section 2001(a) of the Affordable Care Act through a Medicaid 1115 demonstration.

d. § 155.605(e)

We support the proposal to codify in paragraph (e)(4) the IRS guidance that allows certain individuals to claim a hardship exemption directly on their tax forms if they had annual income under 138% FPL but were ineligible for Medicaid due to a state's decision not to expand. We suggest that HHS work with IRS to expand this exemption pathway to individuals who would be Medicaid-expansion eligible but are subject to premiums, waiting periods, or lockouts in states that implemented Medicaid expansion through an 1115 demonstration (see above).

§ 155.610 – Eligibility Process for Exemptions

We support adding paragraph (k) to § 155.610 to define how the Exchange will handle incomplete exemption applications. We agree with the three parts of the process proposed. However, we believe the proposed 10-day minimum to provide the information needed to complete the application is insufficient and will result in many applications not being processed. This may create additional administrative burdens of processing multiple applications seeking the same exemption and unnecessarily burden the appeals process. We recommend requiring Exchanges to provide applicants a minimum of 30 days starting from the date on which notice is sent to provide requested information.

§155.615 – Verification Process Related to Eligibility for Exemptions

We support the proposed paragraph § 155.615(c)(2) to align with the proposed § 155.605(d)(3) to require the Exchange to verify the applicant continued to experience the hardship during a period within 3 years from the exemption application date

§ 155.625 – Options for Conducting Eligibility Determinations for Exemptions

Recognizing State Exchanges continued use of the HHS exemption processing service and HHS' determination that this service has minimized confusion for consumers, we support amending § 155.625(a)(2) and (b) to remove the deadline and permit an Exchange to adopt an HHS-made exemption eligibility determination indefinitely.

§ 155.1000 – Active Purchasing

NHeLP strongly supports HHS' proposal, at 80 Fed. Reg. 75541-41, that Exchanges could take a more active purchasing role in plan certification. We believe that the objective of the Exchange is to create a market that consumers can trust as a source of value, and active purchasing supports this goal.

More specifically, we agree with HHS that Section 1311(e)(1)(B) "affords Exchanges the discretion to deny certification of QHPs that meet minimum QHP certification standards, but are not ultimately in the interests of qualified individuals and qualified employers." Like HHS, we interpret "the 'interest' standard to mean QHPs should provide quality coverage to consumers to meet the Affordable Care Act's goals."

We believe that HHS should evaluate a number of factors in addition to the minimum certification requirements. HHS should consider denying certification to plans that have increased levels of consumer complaints or a track record of standards violations. For example, HHS should consider denial of certification for plans that have a recent history of repeated or egregious violations of:

- Nondiscrimination standards (such as by placing all HIV medications on a highest tier with high cost-sharing);
- Network adequacy requirements;
- Protocols related to consumer complaints and appeals;
- Affordability protections; and
- Coverage and provision of Essential Health Benefits.

Denial of certification for plans that have a poor track record in any of the above areas will create a strong incentive for plans to comply with standards over time. This will make the Marketplace a trusted source of quality coverage for consumers.

§§ 156.20 and 156.298 – Standardization Options

NHeLP is broadly supportive of HHS' proposal at § 156.20 to create standardized plan options for consumers. Although consumer choice is a critical objective, consumers value *meaningful* choice and not solely raw quantity of choices. We agree with HHS that a market with 73 options at one metal level provides a level of complexity that often will create more confusion than true choice and may also reduce enrollment.

Much of the variation in plan options is based on the cost of plans – i.e., cost-sharing design. While consumers are very sensitive to price, complex cost-sharing designs (using copays, cost-sharing, deductibles, etc.) are very difficult to understand or apply with accurate predictive value. Consumers focused on price often choose against their own interests; for example, selecting a lower premium plan that results in higher total spending when cost-sharing is factored in. Complex cost-sharing designs also create a range of options when consumers simply have a singular and *general* goal of overall affordability. In sharp contrast, consumers do have very *specific* interests in other factors – such as whether their providers are covered by a plan and what the plan’s treatment policies are for their health needs. Consumers will be best served if the variety of plans reflects the choices they do care about – providers and treatments – as opposed to an endless number of ways to reconfigure affordability.

HHS’ proposed policy would make standardized plans optional for issuers and also allows them to continue to issue non-standardized options. We believe the best policy is for HHS to eventually limit plans to only the standardized options. This policy would retain significant choices for consumers (based on metal levels, networks, coverage policies, etc.) while making choice manageable and useful. For non-standardized plans in the near term, we think HHS should require issues to have at least one standardized option in every metal tier they sell a plan in, or short of that, at least options in the four silver tier standardized categories (standard silver and the 3 standardized silver cost-sharing reduction options). Without such a policy, the standardized market could be nonexistent or dwarfed by the non-standardized options.

If HHS allows non-standardized plans, we recommend limiting the number of non-standardized plans *in addition* to continuing to apply the meaningful difference standard. With respect to standardized plans, we support the application of the meaningful difference standard, and don’t believe a limit is immediately needed, but HHS should monitor the proliferation of standardized plans in case the number of plans becomes overwhelming.

If HHS’ allows both standardized and non-standardized plans, we strongly agree that standardized plans should be “displayed on HealthCare.gov in a manner that makes it easier for consumers to find and identify them, including distinguishing them from non-standardized plans.”¹⁸ We believe HHS should consider methods to ensure that less sophisticated consumers will start by analyzing standardized plans. For example, simply listing standardized plans first is likely to result in their higher take-up.¹⁹ HHS might also consider ways to make the standardized plans visually distinct (for example, by use of icons) and create some kind branding for standardized plans that identifies the plans as “trustworthy” and offer consumers a simple way to filter out other plans in their searches. We agree that HHS should conduct consumer testing to find additional methods to prioritize standardized plans and communicate well with consumers. We also suggest that standardized plans become the default options for auto-assignment

¹⁸ 80 Fed. Reg. 75,542.

¹⁹ Choice Architecture: Design Decisions that Affect Consumers’ Health Plan Choices. June 9, 2012. http://consumersunion.org/wp-content/uploads/2013/02/Choice_Architecture_Report.pdf.

situations (for example, auto-reassignments after plan changes over the relevant thresholds). We also recommend that HHS create clear and explicit parallel protocols for non-FFE websites that may undermine the simplicity of the standardized option framework. Lastly, as we have previously recommended, HHS should ensure that silver plans are also prioritized through these mechanisms, to maximize the use of cost-sharing reductions for consumers.

We support HHS' policy to use a national standardized standard as opposed to local standardization. While we appreciate this may lead to some premium variance, we believe that consumers will be best served by having uniform standardized categories from market to market. We recognize HHS will face a challenge reconciling the standardized levels with state-specific cost-sharing laws or regulations. However, to the extent permissible, we believe HHS' standardized rates should be used since we are concerned that the state legal or regulatory processes might be used by issuers to undermine standardization or might create confusion. One option would be for HHS to grandfather state-specific policies already in effect on the date of the regulation's issuance. In any event, a state wishing to control its services-specific cost-sharing rates has the option to do so through a state-based Marketplace. We note that many of the states that do run their own Marketplaces are the states which are most interested in creating strong state standards around cost-sharing, meaning that the FFE states are those less likely to have such conflicts. A national standard will also facilitate comparisons across states. In all cases we believe HHS should monitor the policy to identify negative interactions with state policies.

We believe HHS should clarify that this standardization policy applies to all Marketplaces using the FFE platform, including those in states that have taken on some subset of Marketplace responsibilities ("SBE-FP").

We support the inclusion of bronze, silver, three silver cost-sharing variants, and gold levels for standardization. However, we have some concerns with the details of the standardized plans HHS has proposed. While we appreciate that HHS has attempted to develop standardization based on prevalent plan designs, we believe that HHS should not duplicate problematic – and sometimes discriminatory – policies simply because they have been prevalent. Specific suggestions include:

- HHS should prioritize lower deductibles in standard options. Ideally a singular standardized option would exist at each level that would have the lowest deductible feasible. In the alternative, CMS could add a low-deductible option at each level. High deductibles have been shown to reduce utilization of both necessary and less necessary care in roughly equal proportions. Deductibles are also the bluntest cost-sharing tool available when it comes to promoting valued services because they are largely a binary system – they either apply or don't apply. Therefore, deductibles make no distinction among services where they apply, and no distinction among services where they don't apply. (Copayments, as a contrasting example, can be \$0 for highest value services, \$2 for high value services, \$5 for mid-value services, \$10 for low value services, etc., allowing for

more precise valuation of services). Deductibles also have numerous other drawbacks. It is often impossible for consumers to understand which services they apply to and which they do not, and how they interact with copayments and cost-sharing. (HHS should standardize these features if deductibles are retained.) Moreover, deductibles make it difficult for consumers with chronic conditions to evenly spread their expenses over the course of the year and not face huge bills in the first month of care.

- HHS should lower the financial burden on emergency department (ED) services. Under the proposed categories, an appropriate trip to the ED (for example, for a broken arm) could easily cost thousands of dollars. This undermines the purpose of insurance and would lead to delays in ED use even for seriously urgent or emergent circumstances. ED cost-sharing should include a copay only, or perhaps a copayment plus co-insurance, and efforts to reduce inappropriate ED use should focus on more effective strategies such as providing better care coordination for frequent users.
- We recommend adding bronze tier exemptions for preferred brand name drugs and urgent care.
- While we have recommended against HHS allowing high-deductible standardized plans, if HHS allows them then HHS should support consumers in taking advantage of HSA benefits. HHS should facilitate coordination with HSA accounts, including exploring ways to simplify the process and provide consumer education. We do not believe high-deductible plans HSAs are a good coverage model, but consumers should be supported if they are used.

HHS should clarify the meaning of “key set of EHB” that would be subject to standardization within a plan. We are concerned that HHS may have omitted critical services, such as prenatal/maternity care and durable medical equipment, from the standardized structure. Such omissions would only create a new kind of confusion (i.e., the need to parse between services subject and not subject to standardized cost-sharing) for consumers at the same time HHS intends to simplify through standardization. While the standardization might not apply to non-EHB services, it should apply to all EHB services.

Drug tiers make it difficult for consumers to understand or use their coverage. We support the standardization of four drug tiers. We do have concerns that the allowance for additional lower-cost tiers may disrupt the simplicity of the four tier norm, thereby making it harder for consumers to compare plans and easier for issuers to present confusing information. We recommend that if HHS allows lower-cost tiers, HHS should consider ways to minimize the complexity of it. One simple possibility would be for plans to have a list of drugs which have cost-sharing waived. HHS should also prohibit all plans from charging cost-sharing that exceeds the actual cost of the drug. Regardless of how HHS implements the four tier system, the simplicity and value of the design will be greatly diminished if HHS does not create greater standardization around the definitions used by plans to create their tiers. Comparing the tiering of a drug between two plans is useful only to the extent that the tiers actually mean similar things across plans. Finally, we urge HHS to work towards implementing standardized tiering criteria for plans that

require plans to tier drugs in a way that has an evidence-based and rational relationship to the cost of drugs. For example, the Medicare Part D program provides for tiering but requires CMS to approve that the prescription drug coverage and any tiering system have an “actuarial bases provided and reasonably and equitably reflect the revenue requirements.”²⁰ Medicare Part D plans also must provide an exceptions process to tiering.²¹

We support the use of a single in-network provider tier. Reducing the number of tiers in plans will minimize consumer confusion and the potential for excess costs. As described in our comments to § 156.230(a) we recommend that a plans policies that use tiers should also be required to treat any out-of-network provider access that is the result of a shortcoming of the in-network network as if the provider were included in the in-network tier. This would include, for example, situations where the plan has no in-network provider accepting new appointments on a timely basis.

We also support the proposal to standardize exemptions of some services from deductibles. (See discussion above about the concerns with deductibles.) We recommend HHS prioritize exemptions for primary care services (including relevant mental health and reproductive health services) as well as services related to chronic care management. (Preventive services mandated by § 2713 of the ACA should already be exempted from deductibles.) We also support HHS’ proposal to exempt specialist visits and generic drugs. These policies will make it easier for consumers to make comparisons across plans and provide consumers with high-value coverage that promotes long-term health and reduced spending.

We also support the preference for use of copayments over co-insurance, particularly in service categories of coverage with lower cost-fluctuations. As HHS notes, copayments are more transparent (particularly because consumers have very limited understanding of the underlying cost of medical procedures) and predictable for consumers. Moreover, coinsurance may be more discriminatory by placing the heaviest burden of cost-sharing on those with significant health needs. Some states have taken steps to protect consumers from the harmful effects of co-insurance. For example, Colorado now limits co-insurance in health plans and requires issuers to provide at least one plan with only copays.²² Last year, Montana insurance regulators banned co-insurance in all silver-level and higher plans, ending “discriminatory” practices that disproportionately targeted persons with Multiple Sclerosis and cancer.²³

²⁰ 42 C.F.R. § 423.272(b)(1).

²¹ See 42 C.F.R., §§ 423.104(d)(2), 423.578.

²² See Colorado Department of Regulatory Agencies, Division of Insurance, Bulletin No. B-4.82, *Consumer Cost Share for Prescription Drug Benefits* (Jan. 28, 2015).

²³ See Cindy Uken, BILLINGS GAZETTE, Lindeen announces insurance change to help with expensive cancer, MS drugs (Oct. 10, 2014) *available at* http://billingsgazette.com/news/local/lindeen-announces-insurance-change-to-help-with-expensive-cancer-ms/article_7647b4ed-0ba6-5706-8555-c37775bf8de0.html.

Although co-insurance is less predictable for consumers, we recognize that co-insurance may be difficult to eliminate within the actuarial value targets. We recommend that HHS evaluate whether a copayment tiering system (e.g., \$1 for Tier 1 services, \$10 for Tier 2, \$50 for Tier 3, etc.) might provide the actuarial value of co-insurance along with the transparency of copayments. Another mechanism HHS could consider is co-insurance with caps at certain levels (e.g., 20% co-insurance up to \$150). Ultimately, we believe that HHS should not have silver level standardized options that have unlimited cost-insurance higher than 20% (or copayments above equivalent levels), as such co-insurance levels place a heavy and likely discriminatory burden on a subset of consumers with particular health care conditions.

§ 156.122 – Prescription Drug Benefits

a. Exceptions Process

Health plans providing EHBs must have an exceptions process that allows an enrollee to request and gain access to clinically appropriate drugs that are not included in the plan's formulary. Non-formulary prescription drugs available to enrollees through the exceptions process can be a critical component of the enrollee's treatment plan. In the 2016 Payment Notice HHS revised the exceptions process for prescription drugs in order to establish a more uniform process across plans and issuers. HHS clarified that the exceptions process is different from the internal claims and appeals process for enrollees receiving an adverse benefit determination. While the adverse benefit determination process is for a drug that is included in the plan's formulary drug list, the exceptions process is for non-formulary drugs. These exceptions rules will go into effect beginning in January 2016.

However, HHS is now considering amending the exceptions rules to establish that a plan, in a state that has coverage appeals laws or regulations that are more stringent or are in conflict with the EHB exceptions process, and that include reviews for non-formulary drugs, satisfies the exceptions requirements if it complies with the state's coverage appeals laws or regulations. In addition, HHS is proposing that the state determine whether its coverage appeals laws or regulations satisfy § 156.122(c) and decide whether to allow issuers in the state to defer to the states' coverage laws or regulations.

We believe HHS' proposed changes to the exceptions process is a step in the wrong direction. HHS revised the exceptions process for prescription drugs specifically to establish a more uniform process across plans and issuers. States will begin adopting the new exceptions rules in 2016, yet would be allowed to use a different process in 2017.

RECOMMENDATION: We recommend that HHS require states to comply with the EHB exceptions process, which includes an expedited exceptions process, a standard exceptions process, and a secondary external review. Yet, if HHS decides to move forward with allowing state flexibility in determining the exceptions process, then HHS should set some minimum standards and create a tool for states to use in determining whether their appeal laws and regulations are comparable to the EHB exceptions standard.

I. Contraceptive Coverage

Health plans subject to EHB requirements must also cover all Food and Drug Administration (FDA) approved contraceptive methods without cost-sharing as preventive services. Under these rules, if a woman's provider determines that the specific contraceptives covered without cost-sharing in the plan formulary are medically inappropriate for her, the plan must have a waiver process in place to ensure that she can obtain the appropriate contraceptive without cost-sharing. HHS recently specified further requirements for that exceptions process in a May 11, 2015 Frequently Asked Questions (FAQ) guidance to ensure patients have access to contraceptives expeditiously.²⁴

RECOMMENDATION: We recommend that HHS reiterate in the final rule that the contraceptives exceptions process is distinct from the EHB prescription drug exceptions process and that plans must have both in place.

II. Second Level of Internal Review

HHS is considering amending the EHB exceptions process to allow for a second level of internal review. It appears that this is being done to align the process with the rules governing adverse benefit determinations. However, final regulations adopted November 18, 2015 by the Department of Labor (DOL) and Department of Treasury stated:

although the DOL claims procedure regulation permits group health plans to have a second level of internal appeals, these final regulations require health insurance issuers offering individual health insurance coverage to have only one level of internal appeals. This allows the claimant to seek either external review or judicial review immediately after an adverse determination is upheld in the first level of internal appeals.²⁵

Therefore, we believe the EHB exceptions process should also only have one level of internal review. It is unclear how a second level of internal review is beneficial to enrollees trying to gain access to clinically appropriate non-formulary drugs. Without a

²⁴ U.S. Dep't of Health and Human Svcs., U.S. Dep't of Labor, and U.S. Treasury, FAQs on Affordable Care Act Implementation XXVI (May 11, 2015), available at <http://www.dol.gov/ebsa/faqs/faq-aca26.html>.

²⁵ 80 Fed. Reg. 72,192 at 72,224.

doubt, there are instances where enrollees convince health plans to reverse initial decisions; however, the plan-level review is not an impartial review under the law.

RECOMMENDATION: HHS should leave the EHB exceptions process the way it is, with only one level of internal review.

b. Treatment for Opioid Addiction

HHS seeks comments on whether the substance use disorder requirement in the EHBs needs additional clarification with regard to medication-assisted treatment for opioid addiction. We commend HHS for acknowledging that opioid abuse has become a public health crisis and recognizing that some of the most evidence-based substance use disorder (SUD) treatments may not be available to all enrollees as EHBs. The SUD requirement, in general, needs additional clarification to ensure that enrollees are receiving the full continuum of care – outpatient, intermediate levels of care and inpatient treatment - that they need and are entitled to under law. Currently the SUD requirement, including coverage of medication-assisted treatment under EHBs, lacks clarity with regard to scope of services and is, therefore, not effective in ensuring access to federally required care, which is evidence-based and medically necessary.

I. Broader than medication coverage

HHS included the request for comment regarding medication-assisted treatment in the prescription drug benefits section of the proposed rule. Yet treatment that includes a medication component generally goes beyond medication coverage and also consists of counseling and other therapies. While it is imperative that EHBs include comprehensive coverage of all medications approved for the treatment of SUD, it is also important that coverage is provided for evidence-based ancillary care.

II. Methadone Maintenance Treatment Exclusion

The United States Pharmacopeial Convention (USP) Medicare Model Guidelines classification system is used as the comparison tool to determine EHB prescription drug coverage. Health plans must cover at least the greater of 1) one drug in every USP therapeutic category and class or 2) the same number of drugs in each USP category and class as the state's EHB base-benchmark plan. The USP Medicare Model Guidelines version 6.0, which will be incorporated into the EHB prescription drug standard in the 2017 plan year, excludes methadone for treatment of opioid dependency due to federal regulations that require dispensing through accredited facilities. Yet methadone is one of the most common and effective medications used in the treatment of opioid use disorder, therefore it should not be excluded from EHB coverage.

III. Mental Health Parity and Addiction Equity Act

Many health plans and issuers are not in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). The 2017 BBPs are based on 2014 plans, and the final MHPAEA rules did not go into effect until plan years beginning on or after July 1, 2014. The MHPAEA final rule makes it clear that the scope, settings and types of Mental Health/Substance Use Disorder services are nonquantitative treatment limitations and the standards used in developing and applying these plan features must be comparable to and not applied more stringently than the standards for medical/surgical benefits. HHS must ensure that all EHB plans strictly adhere to the MHPAEA's requirements.

On the CCIIO website, HHS noted that the EHB benchmark plans displayed, including those for 2017, may not comply with the MHPAEA. However, the mental health and substance use disorder benefits in EHB plans must comply with the standards implemented under MHPAEA, in order for the plans to satisfy the ACA's definition of "provision of essential health benefits."²⁶ HHS suggests bringing plans into compliance with federal requirements by supplementing plans to comply with MHPAEA. To the extent that plans do not comply with MHPAEA, such supplementation must be explicitly required. HHS should provide states with further guidance and tools on how to use supplementing to bring the final 2017 EHB benchmark plans into compliance with federal requirements, including MHPAEA.

HHS also needs better reporting requirements of covered benefits in order to determine parity compliance. At present, it is often difficult if not impossible for enrollees and regulators to determine if plans are in compliance with MHPAEA. The final rule should contain an explicit requirement that plans demonstrate how their SUD coverage is MHPAEA compliant as a condition of approval.

RECOMMENDATIONS:

- Require coverage of methadone maintenance treatment
- Require plans and issuers to demonstrate compliance with MHPAEA.
- Create tools that states can use to ensure compliance with MHPAEA.
- Clarify for states how they can use supplementation process to meet parity requirements.

§ 156.230 – Network Adequacy Standards

We commend HHS for revisiting these regulations in light of the experience of the second 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.²⁷ We

²⁶ 45 C.F.R. § 156.115(a).

²⁷ See, e.g., Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to J.P. Wieske, Nat'l Assn. Ins. Comm'rs (Jan. 12, 2015), <http://www.healthlaw.org/publications/search-publications/NAICS-Comment>; NHELP, NETWORK ADEQUACY LAWS IN COVERED CALIFORNIA

appreciate that HHS has substantially amended this section to add new provisions aimed at ensuring that QHP enrollees have meaningful access to all essential health benefits. We support the preamble language suggesting that QHP issuers be required to show network resilience for times of natural disaster or other large-scale emergencies.²⁸ We encourage HHS to develop appropriate measures and parameters of network resiliency that can be incorporated into future regulations. We are intrigued by the suggestion in the preamble that HHS develop a system for rating network breadth that could be reported on during QHP enrollment to guide consumers' plan selection.²⁹ We are not aware of any existing state rating systems for network breadth, and the literature on the impact of narrow networks on consumers is quite mixed.³⁰ Thus we suggest that HHS develop this proposal further before implementing.

In addition, HHS requests comments on transparency of issuers' criteria for selecting and tiering providers and whether issuers should be required to make their selecting and tiering criteria available for review and approval by HHS and the state. Although some insurers are using terms like "high value," or "high performing" to describe their networks, there is very little information publicly available about the criteria they use to select or tier providers. However, it often appears that inclusion of providers is being based largely on price, not on the quality of care provided. Moreover, insurers do not use uniform or standardized cost or quality criteria to select or tier providers, and this lack of consistency is confusing both to patients and to providers.

We support requiring insurers to make their criteria for selecting and tiering of providers available both to regulators and to the public. The recently adopted NAIC Network Access and Adequacy Model Act requires insurers to include a description of the criteria they use to build their network and tier providers in their provider directories and in their access plans.³¹ However, we are concerned that these descriptions may be very general and will not provide enough specificity about the quality or other metrics used to be meaningful to regulators or consumers. We therefore urge HHS to require that the specific metrics or factors used to select and tier providers be made available for approval by regulators and to the public.

PLANS (2014), *available at* <http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/network-adequacy-laws-in-covered-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-medicoid-managed-care>.

²⁸ 80 Fed. Reg. at 75,551.

²⁹ 80 Fed. Reg. at 75,552.

³⁰ See, e.g., Katherine Baicker & Helen Levy, *How Narrow a Network Is Too Narrow?*, 175 J. AM. MED. ASSN. 337 (2015), <http://archinte.jamanetwork.com/article.aspx?articleid=2087880>; DAN POLSKY & JANET WEINER, ROBERT WOOD JOHNSON FOUND., *THE SKINNY ON NARROW NETWORKS IN HEALTH INSURANCE MARKETPLACE PLANS* (2015), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027.

³¹ See NAT'L ASSN. INS. COMM'NRS, *HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT § 5(F)(4)* (2015), <http://www.naic.org/store/free/MDL-74.pdf>.

The consumer experience in QHPs in 2014 and 2015 continues to highlight a need for additional regulatory standards governing network adequacy. Consumers in the first two open enrollment periods struggled mightily to understand which 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 proposed regulations go a long way toward addressing some of the most trenchant issues that consumers faced in obtaining needed care from their QHPs.

These problems resulted in significant activity on network adequacy in multiple jurisdictions at multiple levels. In our comments to the proposed updates to these regulations last year, we reported that in 2014, 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, at least 12 states addressed network adequacy in regulation or other administrative guidance, and attorneys filed at least 10 lawsuits in three states alleging network inadequacies in QHPs.³² In 2015, this level of activity has continued. We are aware of three states that passed new network adequacy laws in 2015 and another three state legislatures are already entertaining bills on network adequacy for their 2016 sessions, eight states addressed network adequacy in regulation or administrative guidance in 2015, attorneys filed three new lawsuits in three states alleging network adequacy concerns this year, and state regulators in two states levied fines against two issuers and four providers for failing to comply with state network adequacy rules. In addition, just last month, the National Association of Insurance Commissioners adopted substantial and long-awaited revisions to its Network Adequacy and Access Model Act.³³

Strong HHS regulation of QHP networks is especially warranted since QHPs serve a comparatively vulnerable population. 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 2015 received financial assistance such that they are under 400% FPL.³⁴ Moreover, in 2015, QHPs enrolled nearly 900,000 children under age 18, and over 3 million adults aged 55 and older; these populations are likely to have special health care needs.³⁵ During open enrollment for 2015, QHPs enrolled over 4 million women between the ages of 18 and

³² Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Centers for Medicare & Medicaid Services (Dec. 22, 2014) (comments on HHS Notice of Benefit and Payment Parameters for 2016), <http://www.healthlaw.org/publications/search-publications/nhelp-comments-notice-of-benefit-and-payment-parameter>.

³³ NAT'L ASSN. INS. COMM'NRS, *supra* note 31.

³⁴ DEPT. HEALTH & HUMAN SERVS., OFFICE OF THE ASST. SECT'Y FOR PLANNING AND EVALUATION, HEALTH INSURANCE MARKETPLACES 2015 OPEN ENROLLMENT PERIOD: MARCH ENROLLMENT REPORT 26-27, 33-34 (2015), https://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf.

³⁵ *Id.* at 26, 33.

54.³⁶ A recent report from California noted that 23 percent of 2015 Exchange enrollees in selected a non-English language as their preferred language.³⁷ Similarly, a report on 2015 enrollment in New York’s Exchange found that 18 percent of enrollees there selected a language other than English as their preferred language.³⁸

HHS’s overall approach in this proposal takes some very important steps forward. We appreciate that HHS has responded to previous comments on these regulatory provisions by proposing to require QHP issuers to demonstrate that their plans comply with quantitative standards that measure adequacy, by proposing to require plans to allow consumers to continue seeing their current providers during certain times of transition, and by proposing to require plans to ensure that consumers are not unknowingly seen by out-of-network providers who may then send them surprise bills. We commend HHS for proposing additional consumer protections aimed at ensuring that QHP enrollees can actually obtain the essential health benefits covered under their plans. We urge HHS, however, to go further to adopt more specificity in this regulation to ensure that consumers have robust protections to ensure their access to the essential health benefits through adequate provider networks. We describe our additional suggestions in detail below.

a. § 156.230(a) – *General Requirements*

In 2015, Exchanges continued to offer 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 closed model plans. We recommend that HHS further define and clarify how this section applies to plans with various models.

For example, this year 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 and Missouri, 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.

³⁶ *Id.* at 29.

³⁷ Covered Cal. & Cal. Dept. Health Care Servs., California Eligibility and Enrollment Report: Insurance Affordability Programs (2015),

³⁸ NY STATE OF HEALTH, 2015 OPEN ENROLLMENT REPORT 15-16 (2015), <http://info.nystateofhealth.ny.gov/sites/default/files/2015%20NYSOH%20Open%20Enrollment%20Report.pdf>.

In addition, again this year, many QHP issuers offered plans with tiered networks, such as PPO model plans and tiered HMO model plans. As described above in our comments to §§ 156.20 and 156.298, we support HHS’s proposal to limit the number of tiers a QHP may employ to one, in-network tier. Even so, we remain concerned that too often tiered network plans increase consumer cost-sharing. For example, 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, in 2014 one California woman—Kathleen Moore—enrolled her family in a platinum, no deductible Blue Cross PPO-model plan that contracted with her cardiologist.³⁹ 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.⁴⁰ 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.⁴¹ 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.

We are not aware of a QHP issuer that has offered a traditional health indemnity plan as a QHP option in any Exchange so far, 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.⁴² The ACA does not provide any exception from network adequacy for plans that do not rely on a closed network, nor 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:

³⁹ See *Complaint at* ¶¶ 95-99, *Felser et al. v. Blue Cross, No. BC550739*, (Cal. Sup. Ct., Jul. 8, 2014).

⁴⁰ *Id.* at ¶¶ 99-102.

⁴¹ *Id.* at ¶¶ 95-96, 102.

⁴² 42 U.S.C. § 18031(c)(1)(D)(i).

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—

b. § 156.230(b) – Access to Provider Directory

We appreciate that starting in 2016, HHS will require QHP provider directories to include a range of salient information, including the provider's affiliations, location, capacity for new patients, and specialty type. We urge HHS to require directories to also report on additional information that will help QHP enrollees select their plans and providers appropriately. We recommend that HHS clarify that in reporting on their providers' contact information, QHP issuers should include a phone number and website whenever possible. We also suggest that HHS require issuers to report on their providers' office hours, their anticipated time period for accepting new QHP patients, the physical and programmatic accessibility of the provider's office or facility, whether the provider or facility has pediatric experience, any non-English languages spoken by the provider (for individual providers), and any non-English languages spoken by the provider's or facility's staff.

We emphasize that in requiring QHP issuers to report the languages spoken by network providers and their staff, HHS must ensure 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.⁴³ 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.

Similarly, in reporting on the physical and programmatic accessibility of their contracted providers' offices or facilities, we suggest that HHS adopt an accessibility tool to aid QHPs in assessing the accessibility of their providers to enrollees with disabilities. California has used such a tool in its Medicaid managed care program for the past several years, and has refined the tool through multiple iterations. We recommend this

⁴³ NHeLP, THE HIGH COSTS OF LANGUAGE BARRIERS IN MEDICAL MALPRACTICE (2010), http://www.healthlaw.org/images/stories/High_Costs_of_Language_Barriers_in_Malpractice.pdf.

tool to HHS as a starting point for evaluating and reporting on the accessibility of QHP providers to enrollees with disabilities.⁴⁴

HHS requested comment as to whether it should require issuers to regularly survey contracted providers to determine whether they are accepting new patients.⁴⁵ We urge HHS to incorporate this requirement into the regulation. Ensuring that provider directories are up-to-date is a continuing struggle for consumers, advocates, regulators, and other stakeholders. Surveys in several states this year revealed serious inaccuracies with provider directory listings, and possible underlying gaps in provider networks.⁴⁶ As a result, many states, including California and Rhode Island, have recently incorporated provider surveys as a monitoring tool for evaluating network adequacy and ensuring that provider directory listings are up-to-date.⁴⁷

RECOMMENDATION: We suggest that HHS amend § 156.230(b)(2) as follows:

For plan years beginning on or after January 1, 2016, 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 ***including telephone number and web address, office hours, specialty including whether the provider has pediatric experience, medical group, and any institutional affiliations, languages spoken by the provider or staff, accessibility of the provider's office or facility,*** in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM. ***The QHP issuer must survey its contracted providers to confirm that they are accepting new patients at least once***

⁴⁴ See CAL. DEPT. HEALTH CARE SERVS., SITE REVIEWS: FACILITY SITE REVIEW AND MEDICAL RECORD REVIEW (2014), <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2014/PL14-004.pdf>; CAL. DEPT. HEALTH CARE SERVS., FACILITY SITE REVIEW TOOLS FOR ANCILLARY SERVICES AND COMMUNITY-BASED ADULT SERVICE PROVIDERS (2015), <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-023.pdf>.

⁴⁵ 80 Fed. Reg. at 75,552.

⁴⁶ See, e.g., TRIBAL SELF-GOVERNANCE ADVISORY COMMITTEE, NETWORK ADEQUACY AND ESSENTIAL COMMUNITY PROVIDER INCLUSION IN MARKETPLACE HEALTH PLANS SERVING INDIAN COUNTRY (2015) (many QHPs failed to contract with Indian Health Care Centers), <http://tinyurl.com/j3ty3pl>; MARYLAND WOMEN'S COALITION FOR HEALTH REFORM, NETWORK ADEQUACY IN MARYLAND: A REPORT ON PROVIDER DIRECTORIES AND WOMEN'S ACCESS TO HEALTH CARE (2015) (finding that Maryland QHPs did not provide access to preventive well-woman visits in a timely manner), <http://tinyurl.com/ojn6a6d>; MENTAL HEALTH ASS'N IN NEW JERSEY, MANAGED CARE NETWORK ADEQUACY REPORT (2014) (finding that New Jersey HMOs failed to contract with sufficient numbers of mental health providers), <http://www.mhanj.org/wp-content/uploads/2014/09/Network-Adequacy-Report-Final.pdf>.

⁴⁷ See, e.g., Cal. Dept. Managed Health Care, Submit Health Plan Filings and Reporting, <https://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings.aspx> (last visited Dec. 15, 2015) (containing detailed templates and survey instructions for plans); RHODE ISLAND DEPT. HEALTH, 2015 STATEWIDE HEALTH INVENTORY UTILIZATION AND CAPACITY STUDY (2015), <http://www.health.ri.gov/publications/reports/2015HealthInventory.pdf>.

every three months, and update the directory information within 15 days of a survey response indicating a status change, or any other time the issuer receives notice of a status change. A provider directory is easily accessible when—

c. § 156.230(d)

HHS must establish a national network adequacy standard for QHP issuers, and the same standard should be applied to issuers in state-based marketplaces just as they are in the FFE, and to multi-state plans regulated by OPM just as non-multi-state plans. We appreciate that these proposed rules will require issuers (save MSP issuers) in the FFE to meet federal minimum standards, or state standards approved by HHS. While we support HHS's leaving the states and OPM 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 **all** issuers seeking certification of QHPs.⁴⁸ 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 regulate network adequacy, and have instead delegated this role to their Insurance Commissioners. The Office of Personnel Management, which regulates the MSPs, has adopted anodyne network adequacy regulations that lack any specific or quantitative definition of adequacy, and its implementing guidance has so far failed to provide consumers with any additional protections to ensure real adequacy of their plans.⁴⁹ The result is a confusing patchwork for consumers, that has too often resulted in lack of access. HHS must comply with its mandate under the ACA by adopting a federal minimum standard that will apply to all QHP issuers in all Exchanges.

RECOMMENDATION: We suggest that HHS amend § 156.230(d) as follows:

Minimum threshold. A QHP in a Federally facilitated Exchange meets the standard under paragraph (a)(2) of this section if its network is determined adequate under the following standards:

d. §§ 156.230(d)(1), 156.230(d)(2)

The way the regulation is currently written suggests that HHS will approve state standards that are less stringent than the federal “default” it intends to set forth in the annual letter to issuers. We strongly suggest that HHS set a federal minimum standard, rather than a federal default. A minimum standard will still give states the flexibility to set more detailed or more stringent standards at their option, but will set a floor to ensure that enrollees in all states are enrolled in plans that meet minimum standards. HHS

⁴⁸ 42 U.S.C. § 18031(c)(1)(B).

⁴⁹ See 45 C.F.R. § 800.109; OFFICE OF PERSONNEL MANAGEMENT, MULTI-STATE PLAN PROGRAM CALL LETTER 6 (2014).

should not allow its federal minimum standard to be diluted by states' adopting looser standards.

RECOMMENDATION: We suggest that HHS amend § 156.230(d) as follows:

- (1) In a State that implements an acceptable quantifiable network adequacy metric ***that is more protective than the federal minimums in paragraph (d)(2) of this section*** commonly used in the health insurance industry to measure network adequacy, under that metric; or
- (2) In any other State, under the Federal time and distance ***minimum*** standard ***set forth below***; based on minimum number of providers and average time and distance to those providers. QHPs that cannot meet the time and distance standard established by HHS may satisfy this requirement by reasonably justifying variances from this standard based on such factors as the availability of providers and variables reflected in local patterns of care.

e. § 156.230(d)(2)

We appreciate that HHS plans to set forth specific provider-covered person ratios and geographic access standards for FFE plans in the forthcoming letter to issuers. We commend HHS for taking this enormous step to establish quantitative standards for network adequacy in the Exchanges. As we explained in our comments last year, precise quantitative standards are crucial to ensuring that insurance regulators, consumers, providers, and advocates can equally evaluate whether QHP issuers' networks are adequate. All stakeholders benefit when the standards are clear and easy to measure. We praise HHS for proposing for the first time to use a public quantitative network adequacy standard for QHP issues. Below, we suggest several specific standards that HHS should adopt to measure adequacy, with recommendations about which standards should be incorporated into the regulatory text, and which should be fleshed out in sub-regulatory guidance.

I. Geographic access standards

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.⁵⁰ 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, Medicare, 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.

⁵⁰ See, e.g., Stephen C. Dorner *et al.*, *Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act*, 314 J. AM. MED. ASSN. 1749 (2015), <http://jama.jamanetwork.com/article.aspx?articleid=2466113>.

QHPs that are unable to meet geographic access standards should be encouraged to provide regularly 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.

Because geographic access standards are well-established and tested, we strongly encourage HHS to adopt specific minimum standards into the text of the regulation. The quantitative access standards suggested below, taken as a whole, will strike a balance between reasonable access and issuer flexibility. They are based on the standards that currently apply to all state-licensed plans in California—a large diverse state, with both large urban cities, and many sparsely populated, rural areas. We believe that if the standards that have been tested and work in a large state like California can be applied nationally as a minimum standard that all QHP issuers must meet.

RECOMMENDATION: We suggest that HHS add a new subsection to § 156.230(d)(2)(A) as follows:

(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) 90% of enrollees have a access to behavioral health services within 30 minutes or 15 miles of their homes or workplaces.***
- (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 (2)(A) 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.**

II. Timely access to care

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 of the essential health benefits, 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 provides geographic access to OB/GYNs who provide prenatal care, but it does not contract with any providers who provide counselling and prescriptions for family planning services in its service area, enrollees will not have adequate access to those services. Similarly, in narrow networks, contracted providers may limit the number of QHP enrollees they accept in their practice as patients. The fact that a primary care provider is available a few blocks from an enrollee's home is little comfort to that enrollee if the primary care provider is not accepting new patients.

For this reason, measures of timely access to care are an important complement to provider-covered person ratios and geographic access metrics to help HHS determine with QHP networks are providing real access to the essential health benefits. For this reason, we strongly encourage HHS to also adopt specific regulatory minimum standards for timely access to care. Timely access measures focus on the services provided, rather than the type of provider contracted under a plan. Measuring whether QHP enrollees get access to medically necessary essential health benefits in a timely fashion is fundamental to evaluating whether a plans' network contains the right mix of providers. Thus NHeLP urges HHS to establish clear minimum 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.

The minimum standards we propose here are, like the geographic access standards described above, derived from standards that currently apply to all state-licensed plans in California.

RECOMMENDATION: We suggest that HHS add a new subsection to § 156.230(d)(2)(B), directly following the subsection described above, as follows:

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

III. Provider-covered person ratios

In terms of provider-covered person ratios, NHeLP appreciates that HHS proposes to establish provider-covered person ratios for the specialties with the highest utilization rates in the state. 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. We appreciate that HHS intends to use existing provider-covered person ratios that are used in Medicare Advantage as a starting point for developing ratios for the Exchanges.

We note, however, that those existing Medicare Advantage criteria were developed for a very different population than the demographic enrolled in the Exchanges. QHPs enroll high numbers of children, people with disabilities, limited English proficient enrollees, and women of reproductive age. The Medicare Advantage criteria also do not account for the scope of services contracted providers are willing or able to deliver, nor do they account for the capacity of contracted providers to accept new QHP-enrolled patients. We suggest that this is an area where HHS should invest in studying and refining criteria over time. For the time being, we recommend that HHS annually develop criteria, to be published in a guidance letter, 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, and to account for provider capacity.

RECOMMENDATION: We suggest that HHS add a new subsection to § 156.230(d)(2)(C), directly following the subsection described above, as follows:

(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.

IV. Out-of-network access

We urge HHS to establish specific standards in the regulation 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.

RECOMMENDATION: We suggest that HHS add a new subsection to § 156.230(d)(2)(D), directly following the subsection described above, as follows:

- (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 during a transition as provided for in paragraph (e) of this section.***

V. Language Access

HHS must adopt regulatory 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.⁵¹ 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 and staff (discussed in the section on provider directories, above).

Further, HHS should explicitly require plans pay for interpretation services (both foreign language and sign language as needed) 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

⁵¹ See Cal. Code Regs., tit. 28 § 1300.67.04(c).

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 a new subsection § 156.230(d)(2)(E), directly following the subsection described above, as follows:

(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.

VI. Accessibility to enrollees with disabilities

In addition adopting a facility site review tool, as described in detail above, HHS should adopt minimum regulatory 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 a new subsection § 156.230(d)(2)(F), directly following the subsection described above, as follows:

(F) Physically and programmatically accessible services for enrollees with disabilities. QHP issuers shall establish written standards that comply with guidance set forth by HHS that ensure that provider facilities are accessible to people with disabilities and compliant with Section 1557 of the ACA, the Americans with Disabilities Act and any other applicable state and federal laws.

VII. Monitoring access

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.

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.⁵²

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. This year, California began a five-year process to develop a standard methodology for plans to report on timely access to care and we commend its interim templates and guidance to HHS as a starting point for a national model.⁵³

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 a new subsection to § 156.230(d)(2)(G), directly following the subsection described above, as follows:

***(G) Each QHP issuer shall give assurances to the Exchange and provide—
at least annually—supporting documentation that demonstrates that it***

⁵² See CAL. CODE REGS., tit. 28, § 1300.51.

⁵³ See Cal. Dept. Managed Health Care, *supra* note 47.

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:

(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 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 designated by an "S."; Behavioral Health providers, designated by a "B." And Ancillary health care providers designated by an "A."**
- (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"; and**
- (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.

(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.

(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.

VIII. Corrective Action

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. In the preamble to the proposed rule HHS states that it intends the additional network adequacy standards it is considering to “promote predictability for issuers,” and that it expects that “generally a very small number of plans would be identified as having networks deemed inadequate.”⁵⁴ In order to achieve these goals, it is crucial that HHS permit Exchanges to require QHP issuers to take corrective action when an initial review identifies potential problems with a QHP network. Exchanges must have the power to enforce network adequacy standards—particularly in a climate of ever changing network configurations—in order to address shortcomings in QHP networks identified through regular network reviews, special audits, or consumer complaints. By clarifying in the regulation that Exchanges have this power, HHS can ensure that Exchanges work closely with their contracted QHP issuers to quickly address network gaps in order to ensure that all certified plans do have networks that are deemed adequate.

RECOMMENDATION: We suggest that HHS add a new subsection to § 156.230(d)(2)(H), directly following the subsection described above, as follows:

(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.

⁵⁴ 80 Fed. Reg. at 75,550.

f. § 156.230(e) – *Provider Transitions*

We commend HHS for proposing to explicitly require plans to provide access to out-of-network providers in certain circumstances to ensure continuity of care for the first time. The notice and transition provisions of this proposed rule will go a long way toward ensuring that consumers do not experience abrupt transitions in care or gaps in treatment when their QHP terminates a contract with their providers. Our recommendations below suggest areas where there proposals can be further strengthened.

g. § 156.230(e)(1) – *Notice of Provider Transitions*

We strongly support HHS’s proposal to require QHPs to make a “good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care.” Such notice is crucial in situations where a QHP enrollee has established a relationship a provider to give them time to create a plan to transition care if necessary, or to request continuity of care. Given the important role of primary care providers in coordinating care—particularly for enrollees in HMO-type QHPs—we support the proposal to require notice for all enrollees who have a relationship with a primary care provider who is leaving a plan. For other providers, we agree that notice should be provided to individuals who have seen the provider on a “regular basis,” as proposed.

We suggest that HHS define “regular basis” as having seen the provider once in the preceding 12 months. California uses a once in 12 months standard to determine when Medicaid Managed Care enrollees are eligible for continuity of care protections.⁵⁵ A once in 12 months standard is appropriate, since many enrollees with long-standing but well-controlled chronic conditions will only see their physician specialists on an annual basis. While these visits are relatively infrequent, the physician specialist is often the provider who is responsible for devising and updating the enrollee’s treatment plan (which may be carried out by other non-physician specialists, like nurses, nurse-midwives, CNAs, physical therapists, ABA therapists, LCSWs, etc.), and thus a transition has the potential to significantly disrupt treatment, despite the low frequency of visits to the physician specialist. These kinds of arrangements are particularly common for behavioral health services (e.g., someone sees a psychiatrist annually who prescribes a course of therapy which is carried out by an LCSW or licensed psychologist), and also for certain rehabilitative and habilitative services. Given that the burden on QHPs of providing notice to enrollees is relatively low, we strongly urge HHS to define a “regular basis” generously to ensure that as many enrollees as possible

⁵⁵ See generally Letter from Sarah Brooks, Deputy Dir. Health Care Delivery Sys., Cal. Dept. Health Care Servs., to All Medi-Cal Managed Care Health Plans (Aug. 25, 2015) (guidance letter on Medi-Cal managed care continuity of care policies), <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-019.pdf>

have a chance to prepare for a transition in care. This definition should be incorporated into the regulatory text.

We also support the proposal to require issuers to provide 30 days of advance notice when practicable. For enrollees who need to find a new provider and set-up an appointment in order to avoid a gap in treatment, 30 days will be sufficient, in most cases, to transition care to a different provider. A 30-day notice period is also consistent with the updated Network Access and Adequacy Model Act recently adopted by the National Association of Insurance Commissioners.⁵⁶ We are concerned that a shorter notice period, such as 14 days, would not allow enrollees and their providers sufficient time to create and implement a transition plan.

We note that requiring issuers to provide 30 days of advance notice to enrollees who are patients seen on a regular basis or who receive primary care from the provider who's contract is being discontinued may pose a confidentiality risk to minors or adult dependents who have sought family planning, sexual health, or behavioral health services and wish to keep their services confidential. Generally, communications from an issuer is directed to the policyholder, who is not always the patient of the provider. In particular, we urge HHS to revise and clarify the notification process to balance the goals of provider network transparency while protecting confidentiality and keeping enrollees informed of changes in the provider network through the year.

RECOMMENDATION: We suggest that HHS amend § 156.230(e)(1) as follows:

Make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal. ***Regular basis means that an enrollee has seen the provider at least once in the preceding 12 months.***

h. § 156.230(e)(2) – Continuity during Provider Transitions

We commend HHS for proposing to require issuers to allow enrollees in active treatment to continue seeing their providers, even when those providers are not part of the QHP's current network. We especially appreciate the proposed language in this section that confirms that consumers may only be charged in-network cost-sharing rates when they take advantage of continuity of care protections. This language will ensure that consumers are not subject to high levels of cost-sharing when their plans' provider networks change due to circumstances outside of the consumers' control.

⁵⁶ NAT'L ASSN. INS. COMM'NRS, HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT § 5.L(1)(b) (2015), <http://www.naic.org/store/free/MDL-74.pdf>.

We urge HHS to strengthen this section by broadening the scope of transitions during which enrollees would be eligible for continuity of care protections. We suggest that such protections apply to a variety of circumstances where an enrollee's provider is not in the enrollee's QHP network due to circumstances outside of the enrollee's control. These would include situations where consumers are receiving treatment from a provider whose contract with their plan is not renewed. Exchange enrollees must choose a plan for an entire year but QHP provider contracts may come up for renewal at any time, and non-renewals—just like terminations—leave consumers without the providers who have been providing treatment and coordinating their care.

In addition, we strongly urge HHS to amend this section to extend continuity of care protections to consumers who have been receiving care from a provider and do not have the option to stay with that provider when selecting plans during an enrollment period. In 2014 and 2015, many Exchange enrollees—particularly those who transitioned into the Exchanges from Medicaid—experienced gaps in care when their providers were not included in their QHPs. We expect that in 2016 this problem will be ameliorated in part through more stringent regulation of provider directories aimed at ensuring that consumers know which QHP options contract with their providers, per § 156.230(b)(2). But even when consumers have complete and up-to-date information, there will be instances where none of their QHP options contracts with their preferred providers. For example, Blue Cross in Illinois recently announced that it will no longer sell its PPO product on the Exchange for next year, leaving hundreds of consumers in the state without a plan choice that includes their current providers.⁵⁷ Over the last two years, we have provided assistance in numerous cases where consumers with disabilities and chronic conditions who have close relationships with particular providers did not have the option to enroll in a QHP that contracted with 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 their health. Consumers should not be denied continuity of care during enrollment transitions when they are not offered a choice that allows them to see their existing providers. For this reason, California's Knox-Keene Act affords continuity of care protections to new enrollees whose only plan options do not contract with their providers.⁵⁸ HHS should adopt similar provisions for enrollees in QHPs.

We commend the proposal to require QHPs to provide for ongoing treatment for a life-threatening condition, for serious acute condition, pregnancy, or other ongoing treatment where discontinuing care would cause harm. We generally agree with the definitions of instances of "active treatment" set forth in this section, and we especially appreciate the preamble language that clarifies that "active treatment" is intended to encompass treatment for mental health and substance use disorders that fall within the proposed definition, and we encourage HHS to include this language in the text of the regulation to promote clarity. We urge HHS to retain these proposed provisions.

⁵⁷ Ameet Sachdev, Blue Cross cancellation sends consumers scrambling, Chicago Tribune (Nov. 27, 2015), <http://www.chicagotribune.com/business/ct-blue-cross-ppo-1129-biz-20151127-story.html>.

⁵⁸ CAL. HEALTH & SAFETY CODE § 1373.96(j).

We particularly appreciate that HHS has included a “catch-all provision” to encompass situations where continuity of care is needed that are not captured in the specified categories above. We suggest that HHS clarify the scope of the catch-all further, to clarify that it extends to highly individualized scenarios where continuity is vital because of the relationship between patient and provider. For example, continuity should be extended to lactation consultants for breastfeeding parents. In addition, we urge HHS to further strengthen this important protection: clarifying that it extends to patients with chronic conditions that are being managed, and thus do not necessarily fit the definition of active treatment; and, allowing patients to continue to receive covered services from such a provider, as if the provider were still in-network, through the end of the plan year. Strengthening this provision in these ways would ensure continuity of care for these enrollees, thereby preventing disruptions in access to a provider who has been assisting a patient to manage a chronic condition, which could have a negative impact on patient adherence to treatment regimens and health outcomes—consequences that HHS intends to avoid through the inclusion of this provision in the first place. Additionally, since these individuals often consider provider networks when choosing a health insurance plan, so extending this requirement through the end of the benefit year would facilitate patient access to the network they anticipated when enrolling in a particular plan at the beginning of the year.

We note that there will occasionally be instances where enrollees will require more than 90 days of continued treatment with a nonparticipating provider, and we urge HHS to amend the regulation to permit enrollees to continue care for longer periods when warranted. In particular, we urge HHS to extend the right to continuity of care for pregnancy through the post-partum period, defined as the end of the last day of the month of the 60th day postpartum; this definition is consistent with Medicaid regulations and would give women flexibility when scheduling or rescheduling a postpartum appointment four to six weeks after delivery, which is the interval recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.⁵⁹ We also urge HHS to extend continuity in other cases of active treatment, until treatment is complete. In situations where more than 90 days of treatment is warranted, it makes no more sense to arbitrarily cut access to a nonparticipating provider after 90 days than it does to cut access on the day a provider contract expires. HHS should clarify that the continuity periods provided for in the regulation are minimums, which should be extended when medically warranted, and may be extended voluntarily by a state or plan.

In addition, we urge HHS to clarify that enrollees may request consecutive continuity periods, when they meet the conditions for more than one. For example, when a woman contracts gestational diabetes during pregnancy, she may well need ongoing health treatment during the postpartum period. While gestational diabetes often resolves during the postpartum period, in some cases, gestational diabetes can turn into type 2 diabetes during this period, such that the woman requires ongoing diabetes treatment

⁵⁹ See AM. ACADEMY PEDIATRICS AND AM, COLL. OBSTETRICIANS & GYNECOLOGISTS, GUIDELINES FOR PERINATAL CARE 207 (7th Ed. 2012).

continuing after the postpartum period. In these cases, a woman should be eligible to apply for an additional continuity of care period after the postpartum period concludes.⁶⁰ Further, we strongly recommend that the continuity of care period associated with pregnancy permit enrollees to continue care with any provider who is providing pregnancy-related treatment—not only OB/GYNs, but also mental health providers who treat perinatal depression and other perinatal mood disorders, oncologists who specialize in treatment of gestational cancers, lactation consultants, and a full-range of other provider types.

We commend HHS for clarifying in the proposed regulations that denials or modifications of requests for continuity of care are subject to internal and external grievances and appeals, like any other adverse benefit determination. We suggest that HHS specifically clarify that these grievances and appeals may be expedited, when they meet the criteria for expediting under existing federal and state rules.

RECOMMENDATION: We suggest that HHS amend § 156.230(e)(2) as follows:

In cases where a provider is terminated without cause, ***a provider contract is not renewed, or an enrollee does not have the option to voluntarily enroll in a QHP that contracts with a provider,*** allow an enrollee in active treatment to continue treatment ***at least*** until the treatment is complete ~~or for 90 days,~~ ~~whichever is shorter,~~ ***or in the case of pregnancy, at least until the last day of the month of the 60-day postpartum period,*** at in-network cost-sharing rates.

(i) For the purposes of paragraph (e)(2) of this section, active treatment ***includes treatment for a mental health condition or substance use disorder, and*** means:

...

(D) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes ***including when a breastfeeding parent requests to continue seeing her lactation consultant.***

(I) This section extends to situations where an enrollee with a chronic condition that is being managed, requests to continue to receive covered services from a provider, and continuity in such cases shall extend through the end of the plan year.

...

(iii) In situations where an enrollee begins active treatment for another condition during a continuity of care period, the enrollee may make a second, consecutive request for continuity of care.

⁶⁰ See, e.g., ANDREA TURA ET AL., PROGRESSION TO TYPE 2 DIABETES IN WOMEN WITH FORMER GESTATIONAL DIABETES: TIME TRAJECTORIES OF METABOLIC PARAMETERS (2012), <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0050419>.

i. § 156.230(f) – Out-of-network cost-sharing

We enthusiastically commend HHS for proposing in these regulations to add consumer protections aimed at reducing the incidence of “surprise bills.” As we noted in our comments last year, to ensure that networks are truly adequate, HHS must not permit its QHP issuers to bring in out-of-network providers to perform or assist in the performance of procedures for which consumers have done their due diligence to receive in-network, without the consumers’ knowledge or consent. If a consumer has no real choice to see an in-network provider because, for example, the in-network provider at an in-network hospital that performs her surgery sends a test to be read by an out-of-network pathologist without giving the consumer the option to use an in-network alternative, that consumer’s network is not actually adequate to meet her needs. HHS appears to have drawn heavily from the recently adopted NAIC Network Access and Adequacy Model Act in drafting these proposed revisions. We appreciate HHS’s attention to this issue, and provide feedback on how HHS can strengthen these provisions to better protect consumers from unfair surprise bills and to ensure that their networks are adequate.

We urge HHS to clarify that this section applies not only to plans that use one closed network, such as HMO- and EPO-model plans, but also to plans that use tiered networks. HHS should also clarify that all protections apply at the first tier in any tiered network plans, since QHP issuers are required to ensure network adequacy at the level of the first tier.

We are particularly disappointed by HHS’s proposal to permit surprise billing as long as a QHP counts the balance billing toward the enrollee’s annual limitation on cost-sharing. This anemic provision does nothing to ensure that consumers have access to adequate provider networks that will allow them to avoid unwittingly seeing an out-of-network provider in the first place! To truly demonstrate that their QHPs’ networks are adequate, QHP issuers must be able to ensure that consumers always have the option to use an in-network or first tier provider for all covered services. If a QHP is not able to secure an in-network or first tier provider for a particular service, or to guarantee that an in-network or first tier provider will be used, the consumer **cannot** be held liable for any excess cost-sharing or bills beyond the amount the consumer would pay if the service had been provided by an in-network provider. HHS must revise this provision substantially to instead require that issuers to work out any billing issues with the out-of-network or higher tier providers directly, and to keep the consumer out of any disputes over billing. The promise of network adequacy is gutted by an exclusion that allows consumers to be balance billed by out-of-network providers whom they had no choice not to use.

We particularly recommend that HHS scrutinize QHP networks for the participation of hospital-based physicians at in-network hospitals to ensure that the network includes a sufficient number of such physicians, especially emergency department doctors, anesthesiologists, and radiologists. Recent analysis of data from Texas PPO plans by the Center for Public Policy Priorities found that for two of the largest insurers in the state, 48 percent and 56 percent of their in-network hospitals, respectively, had not a single in-network Emergency Department physician. One plan in particular also reported

that 38 percent of their in-network hospitals had no in-network anesthesiologists and 31 percent had no in-network radiologists.⁶¹ Under HHS's proposed scheme, this kind of network provides consumers with no choice to avoid surprise bills, and utterly fails to meet the promise of network adequacy.

We appreciate that HHS proposed to require QHPs to provide advance notice to consumers when they receive prior authorization for a service that may be provided all or in-part using out-of-network providers. While notice is an excellent first step toward protecting consumers, it is not sufficient by itself. We urge HHS to amend this section to make clear that QHP issuers must ensure that their networks are adequate to ensure that all covered services are available from in-network or first tier providers, and that consumers may not be held liable for costs associated with out-of-network or higher tier providers from whom they did not elect to receive services. Thus, the notice must explain to consumers what steps they can take to ensure that services are provided by an in-network or first tier provider. If the QHP is not able to ensure that the consumer has the option to choose in advance of receiving services to receive care only from in-network providers, the QHP must not permit any out-of-network providers to bill the consumer. Anything less does not provide network adequacy.

Given the importance of these protections, we urge HHS to clarify that QHP issuers may not comply with this section by simply providing a form notice to consumers. Rather, issuers must be required to provide a notice customized to the particulars of each consumer's situation, in order to provide the consumer with a real and meaningful opportunity to avoid a surprise bill by ensuring that all of their care is provided by first tier or in-network providers. Anything less does not provide consumers with any real assurance of network adequacy.

Finally, we note that this new provision does nothing to protect consumers from balance billed amounts related to services provided at out-of-network facilities. While issuers are required to charge in-network cost-sharing rates for emergency services provided at out-of-network facilities, consumers can still be subject to balance bills. Again, given that consumers in an emergency often do not have any control over the facility they are taken to or what the providers treat them, it is particularly unfair that consumers are not protected from these sometimes exorbitant charges. We urge HHS to also provide protection for consumers in this circumstance.

RECOMMENDATION: We suggest that HHS amend § 156.230(f) as follows:

Out-of-network cost sharing. Notwithstanding § 156.130(c), for a network to be deemed adequate, each QHP that uses a provider network, ***including a tiered network***, must:

(1) ~~Count the~~ ***Ensure that any*** cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network provider in an in-network setting,

⁶¹ STACEY POGUE & MEGAN RANDALL, CTR. FOR PUBLIC POLICY PRIORITIES, SURPRISE MEDICAL BILLS TAKE ADVANTAGE OF TEXANS: LITTLE KNOWN PRACTICE CREATES A "SECOND EMERGENCY" FOR ER PATIENTS (2014), http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf.

or by a higher tier provider in a first tier setting, or by any provider when the enrollee receives emergency care, towards does not exceed the amount of cost sharing the enrollee's annual limitation on cost sharing would have paid if the service had been provided by an in-network or first tier provider; or

- (2) Provide a written notice to the enrollee at least ten business days before the provision of the benefit that additional costs may be incurred for an essential health benefit provided by an out-of-network provider in an in-network setting, **or a higher tier provider in a first tier setting**, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing **information as to how an enrollee can ensure that all services are provided by in-network or first tier providers. Such notice shall be customized to the individual circumstances of the enrollee. In the event that the QHP is not able to ensure that all services will be provided by an in-network or first tier provider, the QHP shall ensure that the enrollee is not charged any excess cost-sharing by an out-of-network or higher tier provider, in accordance with paragraph (1) above.**

§ 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. 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. Overall, we have been pleased by the strides HHS has taken 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 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.

We note here that 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.

a. § 156.235(a)(2)

We appreciate that HHS will continue 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 FFE, including MSPs, and QHPs in SBEs and SBE-FPs. We also urge HHS to 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 § 156.235(a)(2) as follows:

A plan applying for QHP certification to be offered through ~~an Federally-facilitated~~ Exchange 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—***

b. §§ 156.235(a)(2)(i) and 156.235(b)(2)(i)

We oppose HHS's proposal to count multiple providers at one location separately.

We are disappointed by HHS's proposal to allow QHPs to count each contracted or employed ECP at a single location as a separate ECP for the purposes of satisfying the participation standard starting in 2018. This proposal will dilute the ECP percentage threshold by permitting QHPs to contract with one large facility that employs or contracts with multiple providers, rather than ensuring that QHPs contract with an array of safety-net providers. The proposal will dilute network adequacy by reducing the number of ECPs to which enrollees have true access, and permitting QHPs to concentrate their ECP contracts in a small number of geographic locations, rather than providing a range of ECPs throughout their service areas.

RECOMMENDATION: We urge HHS **not** to adopt the proposed revisions to these sections.

c. § 156.235(a)(2)(i)

We continue to 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

FFE 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 has required QHPs in the FFM to comply with a 30 percent threshold for the past two years, 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(a)(2)(i) as follows:

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. . . .

d. § 156.235(a)(2)(ii)

NHeLP requests that HHS strengthen the ECP standard by requiring issuers to make good faith efforts to contract with at least one ECP in each category for each geographic region it services. In 2014 and 2015, 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 make reasonable efforts 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. To address these cases, we urge HHS to explicitly incorporate a good faith standard to ensure that QHP issuers have made real efforts to establish contracts with ECPs. We support the language HHS has included in previous letters to issuers specifying 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 include language in the regulation specifying 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 specificity issuers will continue to 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—

e. §§ 156.235(a)(3) and 156.235(b)(3)

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. This provision has the potential to become the exception that swallows the rule. Given the importance of including ECPs in QHP networks, HHS should not provide issuers with leeway to avoid meeting its ECP standards.

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

f. § 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 C.F.R. § 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 QHP 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.

g. Children's Hospitals

We are very concerned that CMS has decided against the disaggregation of children's hospitals from the ECP "hospital" category and we strongly urge you to move forward to propose this disaggregation. We believe the originally intended disaggregation noted in the Final Notice of Benefit and Payment Parameters for 2016 accurately recognized the unique capabilities and expertise located in children's hospitals. The current grouping of children's hospitals with other hospitals allows issuers to contract with lower cost hospitals that do not have the capacity to provide the specialized care that children need, rather than with the children's hospital in their service area. We urge you to ensure that the ECP provisions of the ACA meet their promise of providing vulnerable populations, including children, access to the care they need when they need it.

§ 156.270 – Termination of coverage or enrollment for qualified individuals

In our comments to §§ 155.400 and 155.505 above, we recommend that QHPs be allowed to accept partial payments of premiums from consumers who have appealed their eligibility determinations and that consumers who have appealed be permitted to make partial payments to retain eligibility. For those individuals, the 3-month grace period should continue since the consumer is paying his part of the premium. We recommend HHS amend this section to comport with our recommendations above.

§ 156.1110 – Establishment of Patient safety standards for QHP issuers

We appreciate the inclusion of quality improvement strategies, including patient safety standards, for QHPs and alignment between publicly- and privately-financed quality improvement (QI) programs. For the pediatric population, we urge that the core set of pediatric quality measures established under the CMS/AHRQ Pediatric Quality Measurement Program (PQMP) be referenced for the establishment of all QHP QI structures.

We are pleased that CMS is moving forward to strengthen patient safety standards for the QHPs and support the alignment of the stronger standards with others geared toward the reduction of patient harm. We wish to emphasize the importance of ensuring that the standards reflect all populations. We urge CMS to consider the uniqueness of different populations – including women of childbearing age, children, underserved populations, the elderly and people with disabilities – related to their health care needs, their health care delivery system, quality measures, and health care safety initiatives as it implements this provision. We also believe that patient safety standards and initiatives

must be integrated into the larger quality realm to reflect the objectives established in the National Quality Strategy.

In addition, we are pleased that the patient safety standards under § 156.1110(a)(2)(i)(B) require QHP issuers to ensure that hospitals have implemented a comprehensive person-centered discharge program. It is critical that discharge planning programs reflect the needs of the populations and sub-populations served.

§ 156.1250 – Acceptance of certain third party payments

Insurance premiums and cost sharing such as co-pays and co-insurance can be prohibitively expensive for some consumers, even with Premium Tax Credits (PTCs) and Cost Sharing Reductions (CSRs). Programs such as the Ryan White HIV/AIDS programs provide an essential lifeline by providing low income persons living with HIV/AIDS assistance in paying premiums and cost sharing for prescription drugs.

NHeLP welcomes HHS' leadership in clarifying the obligation of issues to accept third party payments from Ryan White and other federal and state programs that provide premium and cost sharing support for specific individuals, including Indian tribes and tribal organizations.⁶² HHS recognized the important of these programs by making its Interim Final Rule requiring plans to accept certain third party payments effective immediately.

However, persons with other serious or chronic medical conditions have no federal program similar to the Ryan White program. Many of these individuals likewise face high insurance premiums and cost sharing, placing affordable health care out of reach. Some of these individuals rely on charitable Patient Assistance Programs (PAPs) to help defray the costs of important, and in some cases life-saving treatment. Yet these programs do not enjoy the regulatory protection as Ryan White and other federal and state assistance programs. HHS states that it is considering expanding the list of entities from which issuers are required to accept third party payments to include non-profit charitable organizations *in future years*.⁶³

Health advocates report that QHPs and other issuers are refusing third party payments from patient assistance programs, including payments from independent, charitable programs operating within guidelines established by the HHS Office of the Inspector General (OIG).

We strongly urge HHS to immediately require QHPs to accept third party payments from qualified independent, charitable PAPs. HHS should release sub-regulatory guidance

⁶² HHS, Interim Final Rule, *Patient Protection and Affordable Care Act: Third Party Payment of Qualified Health Plan Premiums*, 79 Fed. Reg. 15240 (March 19, 2014) (hereinafter "Interim Final Rule").

⁶³ 80 Fed. Reg. at 75,558.

and by publishing an interim final rule effective immediately, pending the publication of the final rule, just as HHS did for Ryan White HIV/AIDS Program payments.⁶⁴

The urgency surrounding access and affordability is no less great for persons with other medical conditions who can benefit from PAPs. For example, advocates report that approximately 30% of multiple sclerosis patients nationwide dependent on charitable PAPs to obtain often expensive medications.

In comments to the HHS Office for Civil Rights, the American Kidney Fund (AKF) documented an alarming trend among insurers nationwide refusing third party payments to assist with dialysis for persons with End Stage Renal Disease (ESRD). These include:

- BCBS of North Carolina has developed a policy of refusing third party payments with respect to ESRD patients and others. The policy covers all plans, not just those in the Marketplace.
- BCBS of Nebraska has informed patients that it will no longer accept third party payments with respect to ESRD patients and others.
- Moda Health in Oregon has stopped accepting third party payments with respect to ESRD patients and others.
- The group of BCBS plans covering Illinois, Texas, Montana, New Mexico and Montana announced they will refuse third party payments from any entities not mandated by CMS, which includes ESRD patients and others.
- Premera Blue Cross in Washington State has announced it will no longer take third party payments for QHP enrollees, including ESRD patients and others.⁶⁵

As the AKF notes, ESRD disproportionately affects African-Americans who account for 13% of the population, but 32% of the persons with kidney failure in the U.S.⁶⁶

We recognize that third party payments from PAPs may raise program integrity concerns with the HHS Office of the Inspector General (OIG) for potential violations of federal anti-kickback statutes.⁶⁷ Yet in its 2014 Supplemental Special Advisory Bulletin, the HHS OIG distinguishes features of *bona fide* PAPs and those which may violate anti-kickback provisions:

⁶⁴ See Interim Final Rule *supra*, note 62, see also CMS, Q & A - *Third Party Payment of Premiums for Qualified Health Plans in the Marketplaces* (Feb. 7, 2014).

⁶⁵ American Kidney Fund, RE: RIN Number 0945-AA02: Nondiscrimination in Health Programs and Activities Proposed Rule (80 Fed. Reg. 54171), Sept. 8, 2015.

⁶⁶ *Id.* at 4.

⁶⁷ 42 U.S.C. § 1320a7b(b).

We reiterate here than an Independent Charity PAP must not function as a conduit for payments or other benefits from the pharmaceutical manufacturers to patients and must not impermissibly influence beneficiaries' drug choices.⁶⁸

The OIG describes a number of features of qualified Independent Charity PAPs, such as:

- no donor has exerted any direct or indirect influence or control over the charity;
- the charity defines its disease funds in accordance with widely recognized clinical practices and covers a broad spectrum of available treatments;
- the charity does not limit assistance to only high cost or specialty drugs and covers general and bioequivalent drugs;
- the charity does not limit its assistance for only one drug or drugs made or marketed by one manufacturer; and
- eligibility requirements are applied in a reasonable, verifiable, and consistent manner.⁶⁹

If an independent charity PAP meets the guidelines described by the OIG for permissible activities, QHPs should be required to accept those third party payments. We further urge HHS to extend the third party payment requirements beyond QHPs to all issuers that provide EHB, which is consistent with the HHS EHB non-discrimination requirements.⁷⁰

RECOMMENDATION: We recommend HHS amending § 156.1250(a) as follows and add new subsection (4):

- (a) Issuers offering ***EHB and*** individual market QHPs, including stand-alone dental plans, and their downstream entities, must accept premium and cost-sharing payments from the following third-party entities on behalf of plan enrollees:

...

(4) An independent charitable Patient Assistance Program that operates in accordance with the certification requirements established by the HHS Office of the Inspector General.

§ 158.103 – Medical Loss Ratio

NHeLP opposes HHS' proposal to permit issuers to count fraud prevention activities towards the incurred claims used to calculate their medical loss ratios (MLR). Fraud

⁶⁸ HHS OIG, *Supplemental Special Advisory Bulletin: Independent Charity Patient Assistance Programs*, 79 Fed. Reg. 31,120, 31,121 (May 30, 2014).

⁶⁹ Supplemental Special Advisory Bulletin, *see also* HHS OIG, *Modification of OIG Advisory Opinion No. 07-11*, posted Dec. 7, 2015.

⁷⁰ See 45 C.F.R. § 156.125(a) prohibiting EHB plan benefits that discriminate 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."

prevention activities are a classic administrative activity, and the MLR was not intended to count administrative activities in the numerator of medical claims paid. (We agree it is reasonable for HHS to allow issuers to deduct fraud recoveries against incurred claims.)

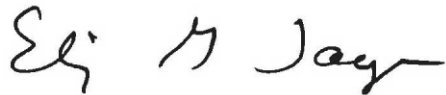
If, against our recommendation, HHS allows fraud prevention activities to count towards medical claims, we support HHS' safeguard proposals to set an upper limit on the allowance and collect expense data.

We generally support efforts by HHS to improve the accuracy of issuer reporting, including by extending the "run-out period," provided that the requirement does not further delay MLR rebates for consumers. Any delays for consumers reduce the effectiveness of the rebate program and can only be justified if necessary to make material improvements in accuracy.

Conclusion

Thank you for your attention to our comments. If you have any questions or need any further information, please contact Mara Youdelman, Managing Attorney (youdelman@healthlaw.org; (202) 289-7661).

Sincerely,



Elizabeth G. Taylor
Executive Director