January 15, 2016

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Acting Administrator
Centers for Medicare & Medicaid Services

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Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services

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

RE: Comments on the Draft 2017 Letter to Issuers in the Federally Facilitated Marketplace

Dear Acting Administrator Slavitt and Administrator Counihan,

Thank you for the opportunity to comment on HHS' draft 2017 Letter to Issuers in the Federally Facilitated Marketplace (FFM). 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.

I. Chapter 1: Certification Process for Qualified Health Plans

Section 4. Standardized Options

We strongly support the proposal to create standardized plan options. We provided detailed suggestions in our comments on the HHS Notice of Benefit and Payment Parameters for 2017[1] proposed regulation. We commend HHS for requiring in the draft 2017 Letter to Issuers (at page 20) that "if an issuer offers a silver

[1] *See* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Andy Slavitt & Kevin Counihan, Cntrs. for Medicare & Medicaid Services at 43 (Dec. 21, 2015) [hereafter NHeLP 2015 BPP Comment] (comments on HHS proposed Notice of Benefit and Payment Parameters for 2017), http://www.healthlaw.org/publications/browse-all-publications/2017-Parameters.

standardized option, the issuer must also offer the standardized silver level cost-sharing reduction variations." However, we reiterate our recommendation that HHS should eventually limit plans to only a defined set of standardized options. In the near term, we think HHS should require issuers 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).

II. Chapter 2: Qualified Health Plan and Stand-Alone Dental Plan Certification Standards

Section 3. Network Adequacy

i. Network Adequacy Standard

We commend HSS for continuing to flesh out network adequacy standards for the FFM in its letter to issuers. We especially appreciate that HHS has again scrutinized FFM QHPs' provider networks closely during the most recent QHP certification period, focusing on areas where consumers have historically experienced access problems, including mental health providers, oncology providers, and primary care providers. We are heartened that, for the first time, the draft 2017 Letter to Issuers proposes specific quantitative access standards that HHS will use to evaluate whether QHP provider networks are adequate, at least in certain situations. As we explained in greater detail in our comments to the proposed Notice of Benefit and Payment Parameters last month, however, we are disappointed that HHS has chosen not to require all plans to meet a minimum access standard, but instead will allow states to implement their own standards if they choose, using the federal standard only as a default when a state fails to select an approved standard.[2] While we greatly appreciate that the draft letter will provide considerably more transparency and detail than prior years, we oppose allowing states to set their own standards which may be less stringent than the federal standard. We urge HHS to establish federal minimum standards, rather than default standards.

ii. State Review of Quantitative Network Adequacy Standard

The draft Letter suggests that HHS will approve state standards that are less stringent than the federal "default" it sets forth in Chapter 2 § 3.iii. 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 should not allow its federal minimum standard to be diluted by states' adopting looser standards.

Moreover, the letter suggests that states may establish network adequacy by reference to only one type of standard. In reality, network adequacy must be measured across multiple dimensions to ensure real access to EHBs. In our comments to the proposed

[2] *Id* at 58-59.

Notice of Benefit and Payment Parameters, we suggested that HHS establish minimum standards not only with respect to geographic access and provider-covered person ratios, but also with respect to timely access, out-of-network access, language access, and disability access.[3] For a QHP enrollee, knowing that her plan's network contracts with a provider a few miles away from her home is little comfort if that provider is not accepting new patients, or the provider's earliest available appointment is months away. Real access requires HHS to use a combination of metrics and standards together, and cannot be accurately assessed by measuring only one dimension of access. We again urge HHS to adopt a variety of network adequacy standards to ensure that all enrollees having meaningful access to EHBs.

We are also concerned that this letter does not set forth sufficient guidance to states on the option to use provider-covered person ratios. The draft letter states that one way states can satisfy the new quantitative network requirement is by verifying "a minimum provider to covered person ratio for the specialties with the highest utilization in the state." (*2017 Draft Letter to Issuers* at 23.) But the letter offers no guidance on how a state may determine which specialties have the highest utilization, nor what specific ratios HHS will accept. We urge HHS to clarify that states must, at a minimum, use ratios for primary care, pediatrics, mental health, and providers of women's health services. We recommend that HHS set federal minimum standards for the appropriate ratios for these services in the final Letter to Issuers, based on the best available clinical information about the number of providers needed in each category to serve QHP enrollees. We also urge HHS to provide additional guidance to states for how many additional specialties it should establish ratios, and how those ratios should be established.

Finally, we are concerned that HHS proposes not only to allow states to set their own thresholds for network adequacy, but also to rely completely on states to monitor and enforce those standards. We appreciate that HHS will respect states' autonomy in monitoring and reviewing their own standards, but we urge HHS not to delegate this function completely. To ensure that all QHPs in the FFE are held to high standards, HHS must reserve the right to selectively monitor and enforce network adequacy compliance for QHPs in the FFE. We envision that HHS would use its right to audit state network adequacy reviews sparingly, if it has reason to believe that a state's review was inadequate.

Finally, we urge HHS to set forth its process for monitoring network adequacy in QHPs with particularity. The draft letter provides very little information about how HHS will oversee and monitor compliance with the federal default standard. In our comments to the proposed Notice of Benefit and Payment Parameters, we urged HHS to require issuers to provide the Exchanges with regular reports of the number of internal and external appeals it received related to network adequacy and timely access, to assist in the monitoring process.[4] We also suggested that HHS require issuers to provide Exchanges with geo-mapping and timely access reports to aid their evaluation of

[3] *Id.* at 51-68.
[4] *See id.* at 68.

network adequacy.[5] We urge HHS to adopt these methods of monitoring access and, in the final letter, require QHP issuers to provide this information to HHS starting in 2017. Lastly, HHS should take compliance actions against any issuers with QHP networks that it finds inadequate.[6]

iii. Federal Default Standard – Time and Distance

We appreciate that HHS has, for the first time, set forth specific geographic access standards for QHPs in the FFE. We commend HHS for drawing upon its experience in the Medicare Advantage context to set specific, quantitative standards for geographic access in the FFE. For clarity, we suggest that HHS more fully explain how and from where the maximum times and distances should be measured—i.e., measured from enrollees' homes using mapping software that measures the travel time and distance accounting for travel patterns and available routes—including accounting for travel by public transportation where that means of transportation is commonly used by enrollees.

We oppose the language in the draft letter that for each listed specialty, an issuer must ensure that there is at least one provider within the plan who meets geographic access for 90% of enrollees. While we generally approve of the proposal to require plans to meet the specified standards with respect to 90% of enrollees, we do not think that this threshold can be met by showing that ***one*** provider is available within the specified geographic range. Rather, we recommend that HHS ensure that at least 90% of enrollees have access to providers who meet the standard—which means that the issuer must ensure a sufficient number of providers available to provide timely access to services within the maximum time and distance to serve 90% of the enrollees. We anticipate that in heavily populated areas and for high-volume practices like women's health, primary care, and dental, this will often mean that the plan will have to contract with more than one provider to satisfy the requirement, and will also have to ensure that the providers it uses to comply with the standard are accepting new patients. In addition, we urge HHS to clarify that when an issuer is not able to provide an enrollee with access to a provider within the standard, it must approve that enrollee to see an out-of-network provider who is available within the maximum geographic area without any additional cost to the enrollee, or if no providers are available within the geographic area, it must provide transportation assistance to the enrollee at no additional cost to the enrollee. Our suggestions are consistent with, and build upon, provisions of the recently adopted NAIC Network Access and Adequacy Model Act.[7]

In addition, with respect to tiered provider networks, we urge HHS to clarify that only providers in the lowest cost-sharing tier will be counted towards meeting the proposed time and distance standards. If QHPs are allowed to count providers who are assigned to a higher cost-sharing tier for purposes of meeting the geographic access standards,

[5] *See id.* at 65-68.
[6] *See id.* at 68.
[7] NAT'L ASSN. INS. COMM'NRS, HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY MODEL ACT § 5(C) (2015), http://www.naic.org/store/free/MDL-74.pdf.

their networks are not truly adequate, since the expose enrollees to the significantly higher costs associated with seeing a higher-tier providers.

As set forth above and in our recent comments to the proposed Notice of Benefit and Payment Parameters last month, we urge HHS to use these standards as minimum standards, rather than default standards.[8] Overall, we agree with the specific standards HHS has selected in this letter. In a few areas, however, we urge HHS to adjust the standards slightly to account for the needs for QHP enrollees.

First, with respect to Gynecology, we urge that the specialty area be broadened, and the specific standard tightened. Naming this specialty area "Gynecology (OB/GYN)" is overly narrow. QHP provider networks must be sufficient to ensure that female enrollees have meaningful access to all covered family planning and sexual health services, including abortion services when they are covered. HHS' narrow focus on OB/GYNs will fail to ensure the adequacy of a plan's network in this regard. Rather, HHS should rename this category "providers of women's health care services," to capture a broader scope of practitioners who offer such services, which include prenatal care, family planning counseling and treatment, abortion services, and screening and treatment for vaginal infections and STIs. Since, in many states, these services are performed by Family Practitioners, Nurse Practitioners, Certified Nurse Midwives, and other provider types, a more expansive category will better capture the adequacy of a plan's network. HHS should also make it clear that both obstetricians and gynecologists are included in this specialty area, as we expect is its intention. In addition, we urge HHS to adopt the same maximum times and distances in this category as the category for primary care. The Medicare standard is not a good fit for this service, since the population served by QHPs includes many more women of childbearing age than the population served by Medicare Advantage. Female enrollees often see providers of women's health care as frequently, or even more frequently, than their primary care providers. This is especially true for pregnant women. It is not reasonable to expect a pregnant woman in her third trimester who lives in a metro area to travel 60 miles roundtrip every week to see the midwife who is providing her prenatal care. HHS should use the same time and distance standards here as it has set forth in the category for primary care.

Similarly, we urge HHS to reduce the time and distance maximums for mental health providers. Again, this is an area where enrollees generally see their providers much more frequently than their primary care providers—often weekly, and sometimes multiple times per week. It is not reasonable to expect an enrollee living in a metro area who is diagnosed with a serious mental health condition that requires weekly therapy to travel 60 miles roundtrip each week for treatment. HHS should reduce the maximum times and distances in this category so they are the same as the standards for primary care. In addition, we urge HHS to require plans to report separately on adult mental health and pediatric mental health providers. Historically, plans have struggled to contract with a sufficient number of pediatric mental health providers, and many adult mental health providers are not equipped to serve the special needs of child enrollees. Thus we recommend that this category be disaggregated so that HHS can pinpoint

[8] *See* NHeLP 2015 BPP Comment at 58-59.

specific shortages for pediatric as opposed to adult mental health providers. For the same reasons, we recommend that HHS separate the category for inpatient psychiatric facility services to track facilities with the capacity to serve adults and those with the capacity to serve children.

In addition, we urge HHS to lower the time and distance maximums for pediatrics. We understand this category to refer to pediatric primary care, not pediatric specialty care. Thus, we see no reason that the maximum times and distances should be three times as long as the standards for general primary care. We urge HHS to more clearly specify that this category refers to pediatric primary care, and to use the same maximum times and distances as it has applied to adult primary care. To account for pediatric specialty needs, we do recommend that, in addition to separating pediatric and adult mental health, as described above, HHS also track pediatric oncology access, both for medical/surgical and radiation/radiology, and that it also separately track pediatric dental separate from adult dental (to the extent that QHPs cover adult dental).

Moreover, with respect to the hospital standards, we suggest that HHS make clear that only acute inpatient hospitals with emergency departments are counted under this standard. HHS should consider measuring inclusion of other types of hospitals, such as children's hospitals, and separate categories should be established for them, as was done for inpatient psychiatric facilities.

Further, we recommend that HHS add categories for services that will be commonly used in all states, including emergency medicine, pharmacy, laboratory, and therapy (including speech, occupational, and physical therapies) services. We recommend that the maximum travel times and distances for these services be set at the same maximums currently proposed for dental care—starting at 30 minutes or 15 miles for large counties and going to 125 minutes or 110 miles for counties with extreme access considerations. These services are fundamental to the care and treatment of the majority of enrollees in QHPs, regardless of location, and we urge HHS to take steps to ensure that enrollees have access to these important services.

With respect to emergency medicine, we strongly urge HHS to add emergency medicine to the list of specialty providers for which there should be time and distance standards and to align those standards with the hospital standards. This would be a way to help HHS identify where there are not adequate numbers of emergency department (ED) physicians in the health plan's network. Many consumers who need emergency care are surprised to receive large balance bills because the ED physician who cared for them was not participating in their health plan's network, even if they were treated at a participating hospital. 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 ED physician.[9] This situation leaves consumers vulnerable to unacceptable balance billing.

[9] 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.

While we simultaneously urge HHS to proactively protect QHP enrollees from billing in these circumstances, we recommend HHS establish time and distance standards for ED physicians to help to ensure that these physicians are being included in health plan networks. While we recognize that Medicare Advantage does not have time and distance standards for ED physicians, Medicare also prohibits balance billing by participating providers and imposes strict limits on balance billing by non-participating providers; these protections make such standards less critical for the Medicare population.

Finally, we understand very rare cases may exist where a QHP is simply unable to meet the minimum standards due to provider shortages. While we agree that QHPs should have some justification process available in these limited circumstances, we urge HHS to ensure that the justification process does not become an exception that swallows the rule. We strongly recommend that, when a QHP is exempted from a particular standard, HHS clearly specify an alternative standard it must meet. For example, if a QHP operating in a CEAC county cannot comply with the standard for primary care, because the only available PCP is located 79 minutes and 64 miles away from most enrollees' homes, that QHP should not be completely exempt from compliance with the primary care standard, but should be required to meet an alternative standard—in this case, 79/64.

iv. Provider Transitions

As set forth in more detail in our comments to the proposed Notice of Benefit and Payment Parameters last month, 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.[10] We strongly support HHS's proposal to require QHPs to make a good faith effort to provide written notice of discontinuation of a provider to enrollees who have seen that provider on a regular basis or who receive primary care.

We also 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. As detailed in our comments to the proposed Notice of Benefit and Payment Parameters, we urge HHS to broaden the scope of transitions during which enrollees would be eligible for continuity of care protections.[11] 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. 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.

[10] *See* NHeLP 2015 BPP Comment at 69-73.
[11] *Id.* at 71.

We continue to support 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. As discussed in detail in our comments on the proposed Notice of Benefit and Payment Parameters, occasional instances will occur where enrollees will require more than 90 days of continued treatment with a nonparticipating provider, and we urge HHS to explicitly ensure that enrollees are entitled to continue care for longer periods when clinically warranted.[12] 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), and in other cases of active treatment, until treatment is complete.

v. Network Transparency

We appreciate HHS's express intention to develop a system for rating network breadth. 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.[13] We are concerned that too often, consumers conflate network ***breadth*** with network ***adequacy***, when in fact there is little evidence to suggest that broad networks are intrinsically better or higher quality than narrow networks. For most consumers, having access to one or two high quality providers who can provide the specific services they need is far more important than theoretical access to a wide network of providers, most of whom offer services that any particular consumer does not require. Moreover, while we certainly agree that consumer choice is one component of adequacy, we are wary that just because a plan contracts with a large number of providers does not mean that consumers actually have access to that full network. Thus we recommend that HHS closely scrutinize the delegation model and referral practices in plan networks so that it can make accurate ratings as to the breadth of QHP networks.

We are concerned that the nomenclature being proposed, particularly the "basic" and "standard" labels, are not clear and could be confusing to consumers. "Basic" and "standard" are too similar and neither term appears to be measuring the same thing as "broad." In addition, "standard" may connote that the network conforms to a specific benchmark. We instead suggest the use of "narrow," "average," and "broad" as terms being more intuitive to consumers. However, as for all consumer-facing tools, we once again strongly urge HHS to conduct consumer testing to inform which terminology to use and how best to display this information for the public. Further, we urge HHS to closely monitor its experience with network breadth ratings this year in general and to evaluate whether this rating system has provided added value to consumers.

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[12] *See id.* at 72-73.

[13] *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.

vi. Out-of-Network Cost Sharing

We enthusiastically commend HHS for proposing to add consumer protections aimed at reducing the incidence of "surprise bills." As described more fully in our comments to the proposed Notice of Benefit and Payment Parameters, 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.[14]

We are disappointed, however, 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. We note that the proposed rule is considerably weaker than the comparable provisions in recently adopted NAIC Network Access and Adequacy Model Act.[15] This 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.

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 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.

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, to provide the consumer with a real and meaningful opportunity to avoid a surprise bill by ensuring that all of the care is provided by first tier or in-network providers. Anything less does not provide consumers with any real assurance of network adequacy.

[14] *See* NHeLP 2015 BPP Comment at 74.
[15] NAT'L ASSN. INS. COMM'NRS, *supra* note 7 at § 7.

Finally, we note that HHS's proposal 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. 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.

Section 4. Essential Community Providers

We appreciate CMS's continued emphasis on ensuring that QHP networks include essential community providers (ECPs). We particularly support CMS's clarification that certain family planning providers who do not receive Title X funds qualify as ECPs. We appreciate that CMS will continue to require issuers to enter contracts with at least 30% of available ECPs in the service area, although we are disappointed that CMS has not increased the ECP threshold. We urge CMS to increase the percentage required in future years and to encourage plans to include a greater number of ECPs above the threshold in their networks to ensure better access and continuity to care.[16]

To ensure meaningful access to ECPs, we suggest that CMS further strengthen the ECP requirements set forth in this letter. In our comments to the Proposed Payment Parameters, we urged HHS require issuers to enter, rather than offer, contracts to at least one ECP in each category, to ensure that all consumers have access to all ECP types. We appreciate that CMS is asking issuers to offer contracts in good faith, in recognition of the rare cases where an issuer may not be able to come to agreement with any ECP in a particular category. But we emphasize that these instances should be very rare indeed and express concern over the weakened definition of "good faith" offers in this year's letter. Under this year's language, an offer would be deemed to be in "good faith" if it contains "contract terms comparable to terms that it offers to a similarly-situated non-ECP provider." This definition is insufficient to ensure that plans take all reasonable efforts to contract with ECPs given that ECPs are often presented with contracts with lower reimbursement rates than other similarly situated providers. 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." For the same reason, we urge CMS to eliminate the option for issuers to provide a narrative justification in lieu of meeting the ECP standard articulated in the letter. We also recommend CMS to explicitly adopt provisions to prohibit issuers from discriminating against ECPs based on the services they provide or the population they serve.[17]

The Department has implemented a new ECP Petition process for qualified ECPs to submit information to stay included on the 2017 ECP list. We support the conditional

[16] NHeLP 2015 BPP Comment at 76-79.
[17] *Id.* at 76.

write-in process to count qualified ECPs towards satisfaction of the ECP standard while the Department and safety-net providers implement the ECP petition process. However, we are concerned that the language in the letter regarding criteria for an ECP petition is not consistent with the instructions for the ECP provider petition. In particular, the letter does not indicate that certain family planning providers recognized as ECPs by statute and regulations (45 C.F.R. § 156.235) are exempt from attestations regarding whether the provider is located in a low-income zip code or HPSA and whether the provider accepts patients regardless of ability to pay and offers a sliding fee schedule.[18] We urge CMS to make the language in the letter consistent with the instructions for the ECP petition.

Finally, we recommend that CMS explain in greater detail in this letter how compliance with the ECP standard will be monitored. We appreciate that CMS has indicated that it will selectively audit issuers that write-in significant numbers of ECPs. We recommend that CMS adopt other monitoring strategies, and account for access to ECPs whenever it monitors network adequacy in general.[19]

Section 10. Discriminatory Benefit Design

NHeLP welcomes HHS' emphasis on addressing discriminatory plan benefit design in both Essential Health Benefits (EHB) and in Qualified Health Plans (QHPs). We appreciate the examples of discriminatory practices by health plans including prescription drug formularies that exclude preferred, commonly prescribed single tablet therapies, unlawful age limits on benefits and services, as well as formularies that place all drugs used in the treatment for certain conditions in the highest cost sharing tiers. We appreciate HHS' examples in the 2017 Draft Letter to Issuers of potential discriminatory benefit design. But further guidance is needed so that states and issuers know how to address this issue.

i. <u>EHB Discriminatory Benefit Design</u>

Issuers will use 2017 EHB benchmark plans when designing their plans, yet many of the approved 2017 benchmarks are not in compliance with federal requirements and some include discriminatory benefit design, which HHS should not permit issuers to replicate.

a. Hearing aids

HHS indicates that arbitrarily limiting coverage of hearing aids to enrollees ages 6 and younger may be discriminatory. Based on a review of the 2017 EHB benchmarks, it appears a number of states only cover hearing aids for children and therefore should remedy this issue. In the Notice of Benefit and Payment Parameters for 2017 proposed

[18] See CNTRS. FOR MEDICARE & MEDICAID, INSTRUCTIONS FOR THE ECP PROVIDER PETITION FOR THE 2017 BENEFIT YEAR 4 (2015), https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/ECP-ProviderPetitionInstructions12-09-15.pdf.
[19] NHeLP 2015 BPP Comment at 76.

rule, HHS states that age limit restrictions may be removed through supplementation. Therefore HHS should ensure that states and issuers remove any discriminatory age limits, and in this case, providing hearing aid coverage for adults as well. HHS should ensure states understand that removing the discriminatory age limit will not create a new state benefit mandate, and therefore states will not have to defray the cost of the benefit.

b. Visit limits

The ACA, in describing requirements of Essential Health Benefit packages, requires that the Secretary "not make coverage decisions…or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life."[20] Section 1557 further prohibits discrimination on the basis of disability. However, EHB benchmark packages and the benefits offered in QHPs continue to include hard limits on the coverage of habilitative and rehabilitative services and devices, especially in a total number of visits allowed. These limits are a de-facto annual monetary cap on coverage, which violates the ACA.[21] Further, these limits discriminate against people with more significant disabilities who need higher levels of therapy. Limitations on the number of covered visits without regard for medical necessity, best medical practices, or the extent of therapy prescribed to the individual discriminates against people with more significant disabilities who need this extensive habilitation or rehabilitation in order to gain, regain, or maintain functioning.

c. Diagnosis-specific benefits contrary to medical evidence

A few issuers have also limited the availability of habilitative services and devices to people with specific diagnoses or developmental disabilities, at the exclusion of people with similar disabilities or health care needs. The EHB category of rehabilitative and habilitative services and devices is a broad grouping of services and supports that benefit a wide variety of people with disabilities, and remediate a wide variety of developmental conditions. The congressional intent of this provision was expressed by The Hon. George Miller, Chairman of the House Committee on Education and Labor, a committee with primary jurisdiction over the House health reform bill, when he explained that the term rehabilitative and habilitative services:

> …includes items and services used to restore functional capacity, minimize limitations on physical and cognitive functions, and maintain or prevent deterioration of functioning. Such services also include training of individuals with mental and physical disabilities to enhance functional development.[22]

Limiting the coverage of habilitative services and devices to people with certain disabilities is discriminatory towards people with other disabilities and fails to ensure that coverage decisions focus on the individualized health care needs of each person.

[20] 42 U.S.C. § 18022(b)(4)(B).
[21] 42 U.S.C. § 300gg–11.
[22] 156 Cong. Rec. H1882 (March 21, 2010)(Statement of Rep. Miller).

d. Prosthetics and Orthotics

The EHB benchmark plan for New York included a policy limiting coverage to only one external prosthetic device, per limb, per lifetime. This benchmark served as the baseline for QHPs in the New York State Marketplace and had severe implications for people with disabilities who needed prosthetics. This policy meant zero coverage for the individual based on their disability once the useable life of their first prosthetic ended. New York's policy was modified in 2015 and effective January 1, 2016 includes coverage of the costs to repair and replace external prosthetic devices for both adults and children. Yet, the Evidence of Coverage document for New York's approved 2017 benchmark (which is based on a 2014 plan) still includes the one prosthetic limb, per lifetime exclusion. Therefore monitoring compliance with the amended policy will be important to ensure that plans/issuers are not including this restriction.

There are also other state benchmarks that either limit or exclude coverage of prosthetics. For example, currently CA's benchmark does not appear to cover prosthetic limbs, and the same benchmark plan was selected for 2017. HHS should clarify that policies such as these are discriminatory and must be eliminated.

e. Monitoring and enforcement

In the 2017 Draft Letter to Issuers, HHS states that "enforcement of this [ACA EHB non-discrimination] standard is largely conducted by states." (*2017 Draft Letter to Issuers* at 46). We disagree with this approach. HHS should be primarily responsible for monitoring and enforcing federal non-discrimination protections.

We recognize that the ACA provides ample opportunities for state flexibility in some implementation areas. However, that flexibility should not apply to monitoring and enforcing the ACA's non-discrimination provisions designed to protect health care consumers, particularly highly vulnerable individuals living with chronic or disabling medical conditions. The same benefit design may be found discriminatory by one state and non-discriminatory by another.

HHS describes a number of monitoring activities to help determine whether plan benefit designs comply with the ACA requirements including the non-discrimination provisions. We welcome these proposals and urge HHS to employ a broad, multi-prong approach to non-discrimination compliance monitoring and enforcement.

When developing new guidance related to discriminatory benefit design, HHS says that per joint interpretative jurisdiction, it will consult with other Federal agencies including the Departments of Labor and Treasury (*2017 Draft Letter to Issuers* at 47). As we discussed in NHeLP's comments on the Department's proposed Section 1557 regulations, HHS has the authority to promulgate government-wide regulations for the implementation of ACA antidiscrimination protections for all health programs and

activities that receive federal financial assistance from any federal agency.[23] We encourage HHS to collaborate expeditiously with other federal agencies, including the Office of Personnel Management, to establish non-discrimination standards and enforcement across multiple agencies. We also urge HHS to engage with the Department of Justice in its role for implementation and enforcement of antidiscrimination requirements.

ii. QHP Discriminatory Benefit Design

We support HHS' proposal to conduct outlier analyses for both services and prescription drugs for specific conditions, examining estimated out-of-pocket costs under recognized treatment guidelines. The five conditions suggested in the Draft Letter – bipolar disorder, diabetes, HIV, rheumatoid arthritis, and schizophrenia, provide a good starting point. However, we are concerned that identifying in advance the conditions to be reviewed may incent plans to adjust their cost sharing structures for these conditions. It might prove more effective to conduct an outlier analysis of additional medical conditions without providing advance notice to issuers.

HHS comments that "[d]iscriminatory cost sharing would typically involve reduction in the generosity of a benefit in some manner for subsets of individuals," (*2017 Draft Letter to Issuers* at 48). We agree. However, discriminatory cost sharing can also mean charging more for services used by persons with certain characteristics or certain medical conditions or populations.[24] For example, plans may charge high cost sharing for mental health services, obstetrics and gynecology, or endocrinologists to discourage persons with significant health needs from enrolling.

Finally, we strongly endorse HHS' recognition that "the mere fact that a benefit design is similar to others does not establish it is non-discriminatory…a benefit design may be discriminatory even it not flagged in outlier analysis" (*2017 Draft Letter to Issuers* at 48).

Section 11. Prescription Drugs

The Final 2016 Benefit & Payment Parameters Rule significantly modified EHB prescription drug requirements.[25] These requirements include the establishment of pharmacy and therapeutics (P&T) committees to work in conjunction with the current United States Pharmacopeia (USP) standard to help ensure the health plan's formulary drug lists cover a broad array of prescription drugs. The 2016 Final Rule also includes

[23] Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Ctrs. for Medicare & Medicaid Servs., Dept. of Health & Human Servs., Re: Proposed Rule RIN 0945-AA02 Nondiscrimination in Health Programs and Activities, 2-3 (Nov. 9, 2015).
[24] For a discussion of "price based" discrimination, see Douglas Jacobs, *The Section 1557 Regulation: What's Missing, And How We Can Include It,* HEALTH AFFAIRS (Sept. 21, 2015), http://healthaffairs.org/blog/2015/09/21/the-section-1557-regulation-whats-missing-and-how-we-can-include-it/.
[25] HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750 (Feb. 27, 2015), *available at* http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf.

standards on P&T membership, meetings, and establishment and development of formulary drug lists. In addition, there are new federal requirements regarding the exceptions process, online formularies, and mail order pharmacies that need to be incorporated into each state's EHB standard.

However, the *2017 Draft Letter to Issuers* fails to mention these important new requirements. Full implementation, oversight and compliance monitoring and enforcement of these new prescription drug requirements will be critical. Accordingly, we urge HHS to address prescription drug coverage requirements, including P&T committees, in the 2017 Letter to Issuers. Moreover, HHS should establish a transparent process to monitor plan compliance and engage stakeholders in implementing the new requirements and monitoring compliance.

i. Formulary Outlier Review

We welcome HHS' plan to conduct formulary outlier reviews of plans, and agree with the recognition that inordinate prior authorization and step therapy requirements may be discriminatory against persons with significant health needs. The *2017 Draft Letter to Issuers* describes a number of data points relating to medical services and prescription drug coverage subject to HHS review, including:

- Cost sharing for medical services and prescription drugs for certain conditions;
- Reasonableness of medical management practices in light of clinical practices and guidelines for certain conditions;
- Unusually high number of drugs subject to prior authorization and/or step therapy requirements in the plan formulary;
- The availability of drugs used to treat certain conditions based on clinical guidelines and cost sharing; and
- Tiering structures and drug placement for high cost, chronic conditions.

(*2017 Draft Letter to Issuers*, 46-49).

We welcome increased plan scrutiny and reviews of plan benefit design. We also support HHS' expanded plan review activities. However, there appears to be some overlap with the outlier reviews described in this section and reviews for QHP medical services and prescription drug coverage described in the preceding and subsequent sections. We urge HHS to clarify how these reviews will be conducted and coordinated. Furthermore, we urge HHS not to limit its plan reviews and outlier analyses to the annual certification process. As indicated above, we maintain that compliance monitoring and enforcement of the ACA's non-discrimination protections should be ongoing. A plan's discriminatory benefit design may not always be detectable during the annual certification process.

Finally, we urge greater transparency during the review process so that plans, state regulators, and advocates can monitor compliance and enforcement activities.

ii. Clinical Guideline-Based Review of Prescription Drug Coverage

NHeLP welcomes HHS' proposal to review the adequacy of plan formularies for specific medical conditions. We appreciate that HHS added a number of conditions, including breast cancer, Hepatitis C, HIV, MS, and prostate cancer to its review list (*2017 Draft Letter to Issuers* at 49). Ending discriminatory plan benefit design, including inadequate prescription drug coverage and high cost sharing requirements, should continue to be a HHS priority.

We encourage HHS to clarify criteria it will use when it considers adding other medical conditions in future years.

iii. Review of Tier Placement of Prescription Drugs Recommended for Treatment of Specific Medical Conditions

In 2014, NHeLP and The AIDS Institute filed a still-pending HIV/AIDS discrimination complaint with the HHS Office for Civil Rights (OCR) against four Florida QHPs that placed all HIV medications, including generics, in the highest tier. By placing even generic drugs on the top tier, patients face high up-front costs in the form of expensive co-insurance and co-pays, as well as burdensome prior authorization requirements and quantity limits. These tactics are particularly hazardous for people living with HIV/AIDS. Gaps in anti-retroviral treatment can lead to the development of drug resistance and increased rates of new HIV infections.

In a study published in the New England Journal of Medicine in January 2015, *Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace*, researchers at the Harvard School of Public Health examined 48 ACA health plans and found that a dozen of these plans placed medications used to treat HIV/AIDS in the highest cost-sharing tiers. This practice — known as "adverse tiering" —serves to discourage people with significant health needs from enrolling in the health plan.

The National Alliance on Mental Illness (NAMI) also identified adverse tiering for medications used in the treatment of mental illness in its April 2015 report: *A Long Road Ahead – Achieving True Parity in Mental Health and Substance Use Care*. NAMI commissioned a study of formularies for 84 health plans to assess coverage of three classes of psychiatric medications: antipsychotics, antidepressants, and SSRIs/SNRIs used commonly to treat depression. The analysis found that many plans placed these medications on high cost sharing tiers or with restricted access.

Adverse tiering can have serious consequences by impeding access to potentially life-saving medications. Adverse tiering benefits insurers by steering persons with significant health needs, such as HIV/AIDS, away from their plans. As a result, plans with more balanced tiering structures become more likely to enroll high-need patients. Consequently, the health plan's enrollment could become imbalanced, placing pressure on the health plan to change its coverage policies or raise premiums and/or deductibles. This can lead to a "race to the bottom" effect where Marketplace plans all start putting

these medications in the highest-cost tiers. Meanwhile, people who most need coverage are left with few options.

HHS comments that "adverse tiering is potentially discriminatory." (*2017 Draft Letter to Issuers* at 49.) We believe, however, that HHS misinterprets the term. All health plan tiering structures, including prescription drug formularies and provider networks are potentially discriminatory. Yet "adverse tiering" is by definition discriminatory because it describes a benefit design that discourages persons with significant health needs from enrolling in the plans or utilizing services. Adverse tiering, like adverse selection or "cherry picking" healthier enrollees, is prohibited under the ACA. We urge HHS to clarify that issuers engaging in adverse tiering of benefits violate the ACA's non-discrimination protections and, if not rectified, will be subject to sanctions.

Section 12. Supporting Informed Consumer Choice/Meaningful Difference

We recommend that HHS implement strong meaningful difference standards to ensure that plans actually provide consumers with options that add value instead of redundant options that crowd the market. The 2017 Letter to Issuers sets out criteria and says that "[s]tates performing plan management functions in the FFMs *may* use a similar approach," (emphasis added) but does not require states to use such criteria. We recommend that HHS take a more prescriptive role to ensure that states, especially those not operating State Based Marketplaces, implement strong meaningful difference criteria.

We support the standardization of meaningful difference criteria and the elimination of extraneous differentiation criteria, including Health Savings Account eligibility, self-only plan offering and non-self-only plan offering.

We have recommended above that HHS eventually require plans to use one of a small set of standardized options. In keeping with the goal of standardization – whether mandatory or optional – HHS should reduce the potential permutations of meaningfully different cost-sharing designs. Under the current parameters, one issuer could design plans with deductibles of $0, $100, $200, $300, etc., resulting in dozens of options based on deductibles, which when combined with multiple options in other criteria, and multiplied by the number of issuers, potentially leaves consumers with dozens and dozens of plans to wade through. We recommend instead that HHS should limit each issuer to offering only two different deductibles or OOP max levels per metal level. At the very least, HHS should boost the threshold for meaningful difference to at least $500 to distinguish plans based only on deductibles or OOP max.

The 2017 Letter to Issuers proposes using provider network IDs as the test of meaningful difference. We think this approach risks allowing plans to achieve meaningful difference through a process that may not indicate more than minor incremental modifications. We believe that HHS should consider a criteria based on network overlap (for example, meaningfully different if the networks have more than

10% unique providers) or some difference in a critical provider entity such as hospital system.

The 2017 Letter to Issuers allows plans to be meaningfully different if there is any difference in the benefits that display on the HealthCare.gov website. While we support having a range of options that will meet the needs of consumers, we believe this standard also allows flexibility to make variations that are not meaningfully different. At the very least HHS (or the state) should retain authority to determine that very minor benefit changes are not meaningfully different. HHS should consider a more objective standard that might, for example, evaluate changes in actuarial value of the benefits changes.

We support HHS' proposal to allow issuers an opportunity to amend submissions identified as not meaningfully different. However, we urge HHS to change its policy allowing exceptions based on "justifications." HHS could eliminate these exceptions. In the alternative, HHS should (1) not allow states using the FFM to issue these exceptions, and (2) set a formal and high standard for the granting of an exception by HHS.

Section14. Cost Sharing Reductions

NHeLP supports the requirement that all QHPs submit three silver plan variations with reduced cost sharing for each silver level QHP an issuer offers, along with zero and limited cost sharing variations for all metal level QHPs. We ask that CMS continue to make efforts to ensure that the SBCs for each silver plan CSR variation be posted and easily accessible through the healthcare.gov website.

III. Chapter 3: Decision Support Tools

Section 1. Provider Directory Links and Provider Lookup Tool

We appreciate that HHS will require issuers in the FFE to share their provider directory listings on a publicly available website, and also to provide them to HHS in a machine-readable file and format. These important protections will help to ensure that consumers have access to accurate and up-to-date information about the providers available from their plans. We encourage HHS in the final letter to require issuers to update their directory listings every 15 days, rather than 30; and also to ensure that directories explain different network options and the consequence of using a higher tier network providers.

As discussed in more detail in our comments to the proposed Notice of Benefit and Payment Parameters, we also urge HHS to increase network transparency by taking additional steps to improve the quality of provider directories.[26] These include requiring issuers to list additional provider information such as telephone numbers, web addresses, office hours, the extent to which the provider is accepting new patients and

[26] *See* NHeLP 2015 BPP Comment at 56-57.

for how long, the extent to which offices are fully accessible to enrollees with disabilities, the ability of the provider's office to provide services in languages other than English, and whether the provider has pediatric experience.[27] We also recommended that HHS require plans to regularly survey providers to ensure that they are accepting new patients.[28] We recommend that HHS include these provisions in the final Letter to Issuers, to improve network transparency.

Section 4. Out-of-Pocket Calculator

Generally, we agree that the calculator adds a critical new mechanism for consumers to evaluate and select the most appropriate plan to suit their needs and may help them more easily weigh the effect of paying slightly higher premiums for lower cost sharing. This is an important educational tool, given that Avalere estimated nearly 2.2 million individuals potentially eligible for CSRs were not receiving them because they selected non-qualifying plans in 2015.[29]

Our comments aim to indicate ways to improve the effectiveness of the current Out-of-Pocket Calculator (OOPC). With a few changes, CMS can ensure the calculator provides an accurate and meaningful projection of total costs and does so in a user-friendly, easy to understand format. However, we believe the current version of the OOPC falls short of this goal.

First and foremost, we agree that any effective OOP calculator must prominently and repeatedly highlight cost sharing reductions (CSRs) that may be available to individuals shopping for coverage. As HHS is aware, the current window-shopping tool still defaults shoppers to plans with the lowest premiums, which are invariably bronze level plans with high OOP burden. Few would argue that consumers who qualify for substantial CSRs (87% or 94% AV) would be better off choosing bronze plans, especially when one considers the potential impact of a high expense medical event. Thus, we strongly support modifying the current tool with several relatively simple fixes that would quickly and significantly improve its value to consumers:

1. Sort the initial results of the calculator to display plans in order of estimated total OOP costs, rather than first sorting by total premium. The tool is billed as an estimate of total costs and it is misleading to default to premiums.

2. Bold or otherwise highlight the requirement that consumers must choose a silver plan to obtain CSRs. Currently, the page that presents the estimated value of a consumer's APTC in the shopping tool mentions the silver level requirement in small, unbolded text at the bottom of the page. This information should also

[27] *Id.*
[28] *Id.* at 57.
[29] AVALERE, MORE THAN 2 MILLION EXCHANGE ENROLLEES FORGO COST-SHARING ASSISTANCE 1 (2015), http://avalere.com/expertise/managed-care/insights/more-than-2-million-exchange-enrollees-forgo-cost-sharing-assistance.

appear when consumers compare or view specific plans (especially for consumers eligible for CSRs at the 87% or 94% AV level).

3. Clarify in the box of estimated healthcare use that each "prescription" refers to a single filled prescription. In other words, six "prescriptions" could mean 6 separate medications filled once, or one medication filled 6 times. As it currently shows, the estimates can easily be misinterpreted to mean separate medications. We suggest wording such as: "XX drug prescriptions filled."

4. Correct the apparent bug involving families with dependent children. The OOPC currently returns only premium costs and no out-of-pocket expense estimates in some cases where the user's household includes dependents under 19. This bug appears to occur when the dependents would qualify for CHIP or Medicaid coverage in that state, but the tool provides no explanation.

We also recommend that CCIIO examine a number of longer term changes that could improve the tool by better educating consumers on the potential value of CSRs and also allow them to customize the calculator to fit their own health profiles:

1. **Emphasize that the calculation is an estimate by presenting a range of potential costs instead of a single average cost.** In previous requests for comment, CCIIO has articulated the concern that the data output for the OOPC could easily be misinterpreted as actual costs, rather than a projected estimate. Unfortunately, we feel that the current configuration of this tool does little to prevent that kind of misinterpretation. At the very least, the next version should round cost sharing to the nearest $100. We believe using a range with rounded numbers would minimize the chance that users mistake the estimated amount for a firm quote of how much they will actually spend out-of-pocket.

2. **Display two results for potential OOP costs**: one that represents "average" use and another that highlights the potential costs of a "bad" year or significant medical event for one family member. Such an approach helps emphasize the value of CSRs to insulate consumers from financial risk. The tool as now designed fails to quantify or educate consumers on the value of risk protection in a "bad" year, despite the fact that such risk protection is arguably the primary purpose of purchasing insurance. The calculator could present results for a "normal" and "bad" years for each plan in comparative bar graphs for each metal level, which could visually demonstrate the difference between bronze and silver plans. The National Health Council's "Putting Patients First" OOP calculator provides a good model for this type of display, though the underlying data appears to be different.[30]

[30] Nat'l Health Council, *Putting Patients First: Estimate My Costs*, http://www.puttingpatientsfirst.net/calc.

3. **Reevaluate the utilization bands.** In the current version of the tool, the difference between "low" and "medium" utilization is far smaller than the difference between "medium" and "high" utilization. This is likely because the curve for health care spending is not a normal curve; rather, health care costs concentrate heavily in the top decile with a very small percentage of individuals accruing the vast majority of expenses. To an average consumer, the "high" expenditure category appears truly extreme and unlikely. But it only takes one injury, significant illness or emergency department visit to generate thousands in medical expenses. One possibility would be to change "medium" to "moderate" and tie it to a slightly higher utilization band.

4. **Use the OOPC to teach about risk and the risk protection that CSRs offer.** One useful message of the OOP calculator beyond quantifying the effect of "average" and "bad" years could be to educate consumers about how likely they are to experience a "bad" year. CCIIO could evaluate how much "churn" is in the top 20% of health care users in a given year, and present that as part of the results. This could be a simple statement like: "An average household similar to yours is likely to have at least one "high" expense user every ___ years." Such information would help people make informed decisions about what plans best fit their needs and what level of risk they want to assume. It might also reduce the likelihood that consumers choose a plan with high cost sharing and then drop coverage because they go into debt after trying to pay toward the unaffordable deductible.

5. **Include a dropdown box that would calculate projected OOP costs for particular healthcare utilization scenarios**, such as an emergency department visit for an accident, a need for "specialty medications," or average costs for maternity coverage. This could help consumers further customize the estimate to match their needs and estimate risks without having to search each plan's Summary of Benefits and Coverage (SBC).

6. **Eventually switch to a QHP-based data source.** Lastly, we understand that the Marketplaces may have not been implemented for long enough to establish a robust utilization data set, but we urge CMS to move toward using base data from Marketplace Qualified Health Plan (QHP) enrollees rather than employer-sponsored insurance (ESI). ESI enrollees on the whole may well have different demographic characteristics and utilization patterns than Marketplace enrollees.[31] We also noted that certain Essential Health Benefits (EHB) services, such as habilitation, are not listed in the OOPC benefit categories. More importantly, we are concerned that such EHB services may not be typically covered by ESI or may be covered to a lesser extent and so may not be accurately represented in the ESI dataset. We encourage CMS to consider what, if any, impact such services might have on cost and utilization. This presents

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

another reason why, in the long run, the best data for the OOPC will come from Marketplace QHPs and Marketplace enrollees themselves.

IV. Chapter 5: Qualified Health Plan Performance and Oversight

Section 3. QHP Issuer Compliance Reviews

HHS states that it will conduct compliance monitoring based on multiple data sources – complaints, issuer self-reporting, issuer policies, procedures, operations, network adequacy analysis and indicators of customer service and satisfaction of plans. (*2017 Draft Letter to Issuers* at 60). We support this approach and expect that HHS will step up review, monitoring and enforcement activities as it ends "good faith compliance." However, HHS does not indicate how it will effectively process and monitor consumer complaints, particularly those complaints concerning non-discrimination and civil rights protections. There are currently multiple entities with overlapping responsibilities to investigate complaints and initiate enforcement actions, including the HHS Office for Civil Rights (OCR), the Office of Consumer Information and Insurance Oversight (CCIIO), the HHS Office of the Inspector General (OIG), the Centers for Medicare & Medicaid Services (CMS), the Department of Justice, as well state insurance regulators. Accordingly, we urge HHS to clarify its reporting and monitoring process for compliance with federal requirements, including non-discrimination.
We support HHS' proposal to conduct different types of compliance reviews of QHPs, including standard reviews, targeted reviews, and expedited reviews. We agree with HHS' proposal to use risk-based process and data collected through its monitoring program to select QHPs for standard review. However, we urge HHS to also conduct randomized reviews of plans to identify issues or deficiencies that may not be captured by the risk-based analysis.

We strongly support HHS' new proposal to make the results of compliance reviews available to the public by posting them to the CMS website. (*2017 Draft Letter to Issuers* at 61). However, we have continuing concerns regarding the lack of transparency in the proposed monitoring and review process, and urge HHS to make the results of its compliance reviews publicly available on an ongoing basis rather than waiting until the end of the year to post the results.

Section 4. FFM Oversight of Agents and Brokers

i. <u>Subsection iii. Monitoring and Oversight</u>

We share HHS' interest in ensuring robust consumer protections exist in the marketplaces to prevent and mitigate harm to consumers from any bad actors, including those who are agents and brokers. We support the changes in HHS's oversight of agents and brokers and enforcement mechanisms as proposed in the 2017 Payment Notice Proposed Rule.[32]

[32] *See* NHeLP 2015 BPP Comment at 23.

In addition, we support HHS' proposal to increase monitoring and oversight of all web-brokers, as outlined in the 2017 Payment Notice Proposed Rule and further recommend that HHS conduct regular audits of all authorized web-brokers throughout each open enrollment period to ensure that these entities are following FFM requirements. If violations are identified during an audit, HHS should work with the web-broker on a plan for the broker to come into compliance.[33]

We also recommend providing specific recourse for consumers who receive misinformation or an erroneous eligibility determination from an agent or broker and are subject to the individual shared responsibility payment (ISRP) or APTC repayment as a result. Our assister network has reported instances of agents and brokers providing misinformation to consumers and erroneously enrolling them in coverage with and without APTCs. Therefore, we recommend providing remedies for consumers in these situations, such as exemptions from the ISRP or safe harbors from APTC repayment provisions so that they do not experience additional harm as a result of agent or broker misconduct.

ii. Subsection iv. Web-brokers

a. Language Access Requirements

We strongly support enforcement of the language access requirements under 42 C.F.R. § 155.205(c)(2) for the 2017 coverage year. Issuers have had a year to prepare for these new requirements and they must be implemented and enforced to ensure language access for limited English proficient consumers. We also commend and support HHS in publishing data identifying the non-English languages triggered by the codified language access standards and sample taglines as soon as possible.

b. Expanded Direct Enrollment Pathways

We want to reiterate our concerns about the scope of what web-brokers may be permitted to do under the 2017 Payment Notice Proposed Rule.[34] In particular, our concerns about allowing web-brokers to use direct enrollment pathways are compounded regarding the potential impact of direct consumer enrollment through web-brokers for 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, we are extremely concerned that web-brokers will abandon Medicaid/CHIP-eligible consumers to navigate their own way through the FFM or State-based Exchanges. 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. We urge HHS to carefully consider the particular implications of direct web-based entity enrollment on this population.

[33] *See id.* at 20-21.
[34] *Id.* at 19-23.

We continue to 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. However, if HHS does allow web-brokers to use expanded direct enrollment pathways, we urge HHS to provide explicit information about how it will maintain the FFM's role in determining eligibility, ensure certain groups are not discriminated against and that all consumers receive comprehensive and accurate information. We strongly support requiring web-based entities to have robust cyber-security systems and 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 caution that if web-brokers use direct enrollment or backdoor portals to HealthCare.gov, HHS must ensure that brokers provide consumers with sufficient information about their application to so that consumers can easily transfer between a broker's website and HealthCare.gov. Thus, as we suggested in our BPP Comment, 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 FFM Call Center to look up an application and make any needed changes. Especially if a web-broker uses a direct enrollment pathway, we urge HHS to require that all pathways provide application numbers 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 start the process from scratch by creating a HealthCare.gov account or always return to the same web-broker.

iii. Subsection v. Compensation

It is important that consumers understand the compensation scheme of agents and brokers in light of the fiduciary relationships that may impact consumers. Agents and brokers owe a fiduciary duty *solely* to the issuer, not to the consumer, and consumers are often not aware of this. Therefore, we recommend that all agents and brokers, including web-brokers, be required to notify consumers that issuers pay them for enrollment.

We support CMS's interpretation that issuers are required under 45 C.F.R. § 156.340 to withhold compensation from affiliated agents and brokers who fail to comply with FFM registration and other applicable Federal requirements.

With respect to the rule requiring QHP issuers to provide the same compensation to agents and brokers for QHPs offered through the FFMs as they do for similar health plans offered in the State outside the Marketplaces, we support using broad criteria to determining whether a health plan is similar to a QHP. We believe this approach will help ensure that agents and brokers are not incentivized to push consumers to non-Marketplace plans. Furthermore, we recommend requiring issuers to provide the same compensation for enrollment in QHPs across metal levels. We have received reports that issuers in SBM states are not compensating agents and brokers for enrollments in gold or platinum level plans and request that the FFM implement protections so

consumers are not steered towards a type of marketplace plan that is not in the consumer's best health or financial interest.

We strongly support enforcement of the rule preventing agents and brokers who are acting as Navigators, certified application counselors, and/or non-Navigator assistance personnel (hereinafter "assisters") from receiving any direct or indirect compensation from health insurance or stop loss insurance issuers in connection with enrolling consumers in a QHP or non-QHP. We further recommend requiring agents and brokers who are acting as assisters and charging consumers directly for services provided to inform consumers in writing that the charges stem from their role as an agent/broker and that the marketplace provides in-person enrollment assistance at no charge.

iv. Subsection vi. Registration Requirement for Re-enrollment Transactions

We strongly support requiring agents and brokers to have a current FFM registration at the time they are assisting consumers with any FFM activities, including re-enrollment. However, we are concerned if an agent/broker's NPN may be listed on the consumer's passive re-enrollment transaction even if the agent/broker is not currently registered with the FFM.

We are unclear from the wording of the draft letter if NPNs are included on passive reenrollment or not. If they are, including NPNs on passive re-enrollment may result in issuers compensating agents/brokers who fail to comply with FFM registration and other applicable Federal requirements, in violation of 45 C.F.R. § 156.340. Second, we think that including NPNs for any agent/broker (whether currently registered with the FFM or not) on passive reenrollment transactions discourages agents and brokers from following up with consumers to help them update their account information and actively re-enroll if they are potentially compensated for the associated transaction. Thus we suggest clarifying that if an NPN is included on a passive enrollment that an insurer may not compensate an agent/broker.

v. Subsection vii. HHS-Approved Vendors of FFM Training and Information Verification

We support HHS' careful vetting and monitoring of vendors who provide training and information verification services to agents and brokers. Ensuring that agents and brokers receive quality training on the FFM is essential to providing consumers with accurate enrollment information and assistance.

V. Chapter 7: Consumer Support and Related Issues

Section 1. Consumer Case Tracking and Resolution.

We commend CMS for' applying consumer support requirements to all QHP and SADP issuers in the FFMs, including in States performing plan management functions, to thoroughly investigate and resolve in a timely manner consumer issues received directly from members or forwarded to the QHP or SADP issuer by the State (through the

issuer's internal customer service process and as required by State law) or by CMS in accordance with the requirements at 45 C.F.R. § 156.1010.

We recommend that the 2017 letter make clear that cases QHP and SADP issuers should investigate (and the CMS should forward) also includes issues related to consumer premium payment disputes generally, as well as cancellations/terminations for any reason (including for non-payment of premiums). Premium payment issues are a common area of dispute between consumers and their QHPs, and these issues need to be further investigated as potential systemic problems re how the QHP and FFM communicate and are held accountable for accurate information impacting the amount of PTCs a consumer is entitled to and whether or not premiums have been paid. We also support CMS' expectations that QHP and SADP issuers operating in the FFMs and SBM-FPs conduct appropriate research in a comprehensive manner using all of the tools and systems available to them, as well as contact consumers as appropriate to conduct their investigations and research in order to ensure that issuers are using the most recent information available from the consumer. Finally, we commend CMS for clearly stating that QHP and SADP issuers operating in the FFMs, including in States performing plan management functions, and in SBM-FPs, are expected to comply with all applicable State and Federal laws related to consumer complaints, including any applicable requirement to advise consumers of their appeal rights. We suggest CMS make clear in the 2017 letter how it intends to tracks consumer cases and uses the information to direct oversight activities in the FFMs and SBM-FPs.

Section 2. Coverage Appeals

We commend CCIIO for including coverage appeals in the 2017 letter to issuers and applying this section to all QHP issuers in the FFM, including in states performing plan management functions. We are, however, disappointed that this letter does not apply to SADPs, as dental plan coverage is essential and having no guidance regarding appeals of adverse benefits determinations leaves consumers vulnerable to having essential dental benefits denied without CCIIO oversight.

We strongly support continuing to require QHPs to meet the same standards for internal claims and appeals and external review, as established in the recently finalized regulations, at 45 C.F.R. § 147.136.[35] We ask that HHS provide additional guidance in the 2017 letter to the QHPs as to how HHS intends to monitor plans to ensure they fully comply with the requirements of 45 C.F.R. § 147.136, including the notice and appeal rights provisions governing internal and external review.

[35] 45 C.F.R. § 147.136 implements section 2719 of the PHS Act, as added by the Affordable Care Act (requiring all non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage to implement an effective process for internal claims and appeals and external review).

Section 3. Meaningful Access

We appreciate the summary in this section of the meaningful access provisions applicable to QHP issuers, including SADP issuers. As outlined in the 2016 final Letter to Issuers, HHS adopted a number of requirements regarding language access that would become applicable in the 2017 plan year. We appreciate the reiteration of those requirements and the specifications included in this letter. Current enrolment data shows Latinos are lagging behind other groups in enrollment so it is critical that language access and meaningful access be provided to all limited English proficient individuals to ensure they can benefit from all the provisions of the ACA.

We support the delineation of the documents that are designated as essential and the separate recognition that any document required to be provided by state or federal law or regulations are also included. We would suggest adding in all notices regarding payment (including non-payment) to this list.

We appreciate the cross-reference to other applicable civil rights laws, including Section 1557.

Section 4. Summary of Benefits and Coverage

Given that the current regulations governing translation of the Summary of Benefits and Coverage (SBC) and taglines differ from the applicable meaningful access requirements finalized in the 2016 Benefit & Payment Parameter rule, we strongly suggest that HHS include language in this section that reiterates the requirements outlined in Section3 and that the SBC, as a document mandated by Federal law and regulation, must meet the requirements outlined in the applicable regulations cited in Section 4.

We also strongly support the letter's inclusion of the recognition that abortion services must be disclosed on the SBC. The letter states: "In addition, the final regulations require a QHP issuer to disclose on the SBC whether non-excepted abortion services as well as excepted abortion services (that is, those abortion services for which public funding is permitted) are covered or excluded, consistent with the manner specified in guidance by the Secretary." (*Draft Letter to Issuers* at 81.)

VI. Chapter 9: State-Based Marketplaces on the Federal Platform

We appreciate the reiteration of the requirements from the proposed 2017 Benefit & Payment Parameter rule that SBM-FPs must enforce certain QHP and QHP issuer requirements that are no less strict than those HHS applies to QHPs and QHP issuers in the FFM. We would strongly recommend adding the meaningful access requirements (45 C.F.R. §§ 155.205(c), 155.230(b) and 156.250) as well as the nondiscrimination prohibitions (45 C.F.R. § 156.200(e)) to this list. Further, we support HHS' enforcement of these standards against SBM-FP issuers and QHPs when the SBM-FP is not substantially enforcing one or more of the requirements.

VII. 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