October 6, 2016

Kevin Counihan
Administrator
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: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018 (CMS-9934-P/RIN 0938-AS95)

Dear Administrator Counihan,

Thank you for the opportunity to comment on HHS' proposed HHS Notice of Benefit and Payment Parameters for 2018 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.

We have included our comments on specific sections below.

§ 147.104 – Guaranteed Availability of Coverage

We appreciate the specificity in this section about required open enrollment periods and support its finalization.

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§ 153.320 – Federally certified risk adjustment methodology. ("Prescription Drug Hybrid Model")

a. Partial Year Enrollment

As noted below in our comments on SEPs, we generally support incorporating enrollment duration into the risk adjustment model. We thus support the proposal to recalibrate the 2017 risk adjustment adult model to reflect the incorporation of partial year enrollment duration (ED) factors and to incorporate partial year ED factors in the risk adjustment model methodology starting with the 2017 benefit year. This would ensure that risk adjustment better accounts for any higher (or lower) costs associated with partial year enrollees. That includes individuals purchasing Marketplace coverage after the end of the Open Enrollment Period because they are eligible for Special Enrollment Periods (SEPs) due to changes in life circumstances such as birth of a child, marriage or divorce, a permanent home or loss of other health insurance coverage. We believe that this is the appropriate approach to address any cost differences resulting from SEP enrollees than unduly restricting the use of SEPs by otherwise eligible individuals.

b. Prescription Drug Hybrid Model

We recognize the complexity of the reinsurance, risk corridors, and risk adjustment programs. However, we do wish to stress that methodologies appropriately accommodate for the needs of individuals with disabilities and chronic conditions. The alternative would mean applying an unfair standard of care to these populations (i.e. a standard of the average patient, rather than a more complex standard), thus increasing the chances of stinting on patient care to those who need it most.

Thus, NHeLP supports including prescription drug data in the Risk Adjustment Model to mitigate the financial disincentive to prescribe expensive medications. Compensating plans for enrollees who need and use higher-cost prescriptions will encourage insurers to take responsibility for caring for these patients, remove incentives for avoiding the sickest patients, and reduce discriminatory practices that prevent vulnerable populations from accessing care and treatment. Moreover, the hybrid model described by HHS in its March, 2016 *Operated Risk Adjustment Methodology Meeting Discussion Paper* provides a practical approach to risk adjustment.[1]

[1] Centers for Medicare & Medicaid Services, March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting Discussion Paper (March 24, 2016) [hereinafter "CMS Discussion Paper"].

We appreciate the operational complexities of collecting and analyzing both drug utilization and diagnosis data. The classes of drugs HHS is proposing to include in risk adjustment for 2017, including Antiretroviral therapy (ART) used to treat HIV, are well-suited for indicating severity of an enrollee's condition as well as, for most of the classes, imputing diagnoses.

Antiretroviral drugs may be prescribed to individuals who are not HIV positive to prevent HIV either as a pre-exposure prophylaxis (PrEP) or as a post-exposure prophylaxis (PEP). Only one antiretroviral, Truvada, is prescribed as pre-exposure prophylaxis (PrEP).[2] When Truvada is prescribed to treat HIV, as opposed to prevent infection, it is always prescribed in combination with other HIV medicines. Therefore, we believe it would be possible to subdivide the HIV Prescription Drug Category into Truvada-only, which would not impute an HIV diagnosis, and all other HIV prescriptions (including Truvada plus other antiretrovirals), which would impute an HIV diagnosis.

While multiple antiretroviral medications may be prescribed as post-exposure prophylaxis (PEP), PEP can be identified by the number of days it has been prescribed. A patient being treated for HIV would be indicated by prolonged usage, whereas someone receiving medication to prevent infection post-exposure would be prescribed only 28 days' worth of antiretrovirals.[3]

We agree that an effective risk adjustment program should foster marketplaces where insurers are rewarded for providing high-quality, affordable coverage, not for offering plans designed to attract the healthy and avoid the sick.

§ 153.610 – Risk Adjustment Issuer Data Requirements

We support the comments from the Center on Budget and Policies Priorities with regard to this section.

§ 153.630 – Data Validation Requirements When HHS Operates Risk Adjustment

We support the comments from the Center on Budget and Policies Priorities with regard to this section.

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[2] Centers for Disease Control and Prevention, HIV Risk and Prevention, at http://www.cdc.gov/hiv/risk/prep/.

[3] See Centers for Disease Control and Prevention, *Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV—United States*, 2016, pp. 7-8, available at http://stacks.cdc.gov/view/cdc/38856

§ 155.20 – Definitions (Standardized Option)

In our comments to the NBPP 2017 proposed rule (proposed in December 2015), we commended the development of standardized plan options. Plans that share a common benefits structure, including tiering and cost sharing, allows consumers to make apples-to-apples comparisons of plans and benefits. We also believe there is great value for consumers in simplified options, particularly when those options match high-value designs. While we believe it makes sense for HHS to consider the most *popular* designs as models for setting standard plans (as it reduces disruptions), we also believe HHS should prioritize designs that promote *high-value* designs. High-value designs are those which promote easier access-to-care, especially for highly cost-effective services (such as designs with lower copayments and deductibles), as opposed to low up-front costs that likely hinders access-to-care due to high out-of-pocket costs (such as designs with low premiums but very high deductibles or co-insurance). The popularity of a design is not in itself evidence that the design is valuable; sometimes designs are popular due to misunderstanding or the lack of well-known, better alternatives.

We also have concerns related to several policies related to definitions and standardized options, including high deductible health plans, cost-sharing for habilitation, and specialty drug tiering.

a. Accommodation for State Laws

We support the inclusion of new standardized design options to make accommodation for states that have state cost-sharing laws. We believe HHS should clarify that this policy is designed to create flexibility for state laws that improve, and do not undermine, standardized designs.

b. High Deductible Health Plans

We are concerned about the inclusion of high deductible health plans (HDHPs) to the standardized options. HDHPs may attract consumers with low premiums, but are not suitable for anyone with a disability or chronic condition. HDHPs have failed at achieving the policy aims for which they were devised. People enrolled in HDHPs do not utilize health care more efficiently or "smarter" because they have "skin in the game." Instead, enrollees use less health care across the board, including preventive or other necessary care. The fact that 9.2% of enrollees choose such a plan is likely due to the deceptive low cost and in many cases misunderstanding about how the coverage works. HDHPs do not save money long term, instead provide *at best* short-term savings

that disappear in the long-term.[4] Just like standardizing inadequate therapy benefits normalizes subpar services, standardizing HDHPs could further systematize this new benefit structure and confuse consumers.

If HHS nonetheless moves forward with the standardized HDHP, we also reiterate that CMS should develop clearer consumer materials that explain how deductibles work and emphasize services that are covered even if someone has not met the deductible. Misunderstanding of this cost sharing feature remains very high and likely leads enrollees to forego preventive care unnecessarily. We also note that many people with HDHP plans never actually establish a tax-sheltered savings account, and, should HHS go forward, we urge it to raise awareness of this feature and facilitate enrollees' ability to take advantage of that benefit.

c. Habilitation

We continue to support exempting additional services from the deductible, including primary care and specialty visits, and we would like to urge HHS to add habilitative services to the list rather than limiting the exemption to rehabilitative services. Particularly for children with disabilities and chronic illnesses, coverage of habilitative services is critical. For those who may have a condition at birth, such as cerebral palsy, spina bifida or autism, or have experienced an illness or injury that prevents normal skills development and functioning (such as a brain injury), habilitative services should be available early and consistently for the best and most cost-effective outcome.

The Proposed Rule also adds three new sets of standardized options for the 2018 plan year (Tables 12, 13 and 14). Table 13 is a set of standardized options designed to work in states that require that cost sharing for physical therapy, occupational therapy and speech therapy be no greater than the cost sharing for primary care visits. While these proposals only apply to the standardized option, we commend CMS in its attempt to align the cost sharing for physical therapy, occupational therapy and speech therapy with primary care visits. If finalized, these policies will increase consumer access and limit the financial barriers to therapy services.

However, in Tables 12-14, Proposed 2018 Standardized Options, CMS lists "Speech Therapy" and "Occupational Therapy/Physical Therapy" but does not list habilitative services, indicating that rehabilitative services are subject to a coinsurance but habilitative services are not. Co-insurance imposes a greater financial burden on persons who need these types of services. Moreover, plans do not indicate what the

[4] http://www.healthlaw.org/publications/search-publications/nhelp-federal-comments-to-health-indiana-1115-demonstrations#.V-A8pfkrLIU.

actual estimated out-of-pocket costs would be under co-insurance. We request clarification on this point, and suggest that both rehabilitative and habilitative services and devices in the Exchanges be exempt from co-insurance. We request:

- this exemption based on the understanding that habitation and rehabilitation are to be treated the same;
- that occupational therapy and physical therapy be considered separate and distinct therapy services, similarly to how rehabilitative speech therapy is listed separately; and,
- that cost-sharing be reasonable in order to not be a barrier to consumers accessing necessary therapy services.

d. Prescription Drugs

With regards to prescription drugs, while we are pleased to see HHS' proposal to continue reasonable co-pays rather than co-insurance for most Simple Choices plans and tiers, we are concerned with the use of high co-insurance for all drugs on the "Specialty Drug" tier and in most bronze plan tiers. The use of coinsurance amounts to a total lack of transparency. As beneficiaries cannot access drug price information prior to choosing a plan to calculate the dollar amount they will have to pay, such cost-sharing designs significantly disadvantage individuals who rely on prescription drugs to manage their chronic conditions during the plan selection process and can be characterized as discriminatory.

Co-insurance often results in high beneficiary costs that place medications out of reach for most patients and reduces medication adherence. Frequently, issuers place a high number of drugs to treat an individual health condition on the specialty tier. This can result in discriminatory plan design. These plans that use adverse tiering are disproportionately forcing beneficiary cost sharing on prescription drug benefits and discourage beneficiaries with chronic conditions from enrolling. This is in violation of the strong non-discrimination provisions included in the ACA. Some issuers have successfully designed plans that limit patient cost-sharing to reasonable and affordable co-pays, and we encourage HHS to use the Simple Choice plans to lead issuers in this direction. Therefore, we strongly oppose the use of co-insurance for the "Specialty Drug" tier across all metal levels and in all tiers (except for generics) in the Bronze plans.

We are concerned that HHS is proposing to remove the deductible exemption for specialty tier drugs at the Silver and 73 percent cost-sharing reduction (CSR) plans. Although the proposed addition of separate drug deductibles at these levels provides

some protection, it may actually increase patient cost-sharing. Furthermore, while we strongly support not applying the deductible at all to any tiers of drug coverage under the 87 percent CSR, 94 percent CSR, and Gold plans, we are concerned that listing a separate $0 Rx deductible for these plans adds confusion for beneficiaries.

e. Differential Display

We are disappointed that state-designed standardized plans (in SBE-FPs) will not receive differential display on the HealthCare.gov website. We encourage HHS to develop this capacity. In such states, we believe the default should be to display the HHS-designed standardized options, unless the state designs its own standardized plans and opts out. We strongly support this in states that do not develop standardized options of their own.

§ 155.205 – Consumer Assistance Tools and Programs of an Exchange

We have some concerns about the aggregation of LEP populations as outlined in the proposed regulation.

We are concerned with the proposal to allow aggregation, particularly for large entities that work across many states. In part this is due to the ongoing consolidation of issuers in the healthcare arena. As more issuers merge, forming bigger conglomerates that operate across larger and larger swaths of the country, allowing aggregation will likely result in a loss of one of the 2 important policy objectives recognized by HHS in the preamble – ensuring that LEP individuals have notice of language assistance services. While we recognize the competing objective of minimizing burdens on entities subject to the rule, we are very concerned that taglines often provide the only in-language information to LEP individuals, who may comprise up to 25% of marketplace customers.

For example, Kaiser Permanente is participating in state-based exchanges in California, Washington, Colorado, Maryland, and DC. If it aggregates the LEP populations across these states, using HHS's data, even though there are more than 27,000 people with limited English proficiency in California who speak Thai, that language does not rise to the top 15 languages.[5] In the remaining states, a number of languages would no longer have taglines:

[5] See Attachment A below. Data source is Appendix A – Top 15 Non-English Languages by State. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf

- In Washington, we lose taglines for Amharic, German, Cushite, Ukranian, and Laotian;
- In Colorado, we lose taglines for Amharic, German, French, Nepali, Cushite, and Kru/Ibo/Yoruba;
- In Maryland, we lose taglines for Amharic, French, Kru/Ibo/Yoruba, Urdu, French Creole, and Gujarati; and
- In DC, we lose taglines for Amharic, German, French, Kru/Ibo/Yoruba, Portuguese, Italian, and Bengali.

We believe that this rule should differ from the final regulations implementing Section 1557 in that many of the entities covered by this rule – including the Exchanges and issuers – operate at a much larger scope than the entities covered by Section 1557 and have greater resources to bring to bear to help inform LEP individuals of their rights. While many may be covered by both rules, the Section 1557 rules were necessarily written to cover a broader array of covered entities that this rule of a variety of sizes – from a solo practitioner to a large hospital to a multi-state issuer. We thus believe that greater specificity, and greater requirements, is justified in this rule given the fact that many of the entities are much larger and both financially and programmatically able to provide greater taglines.

We believe that once an entity has to provide taglines, an entity that seeks to aggregate should first include as many taglines as will fit on one page rather than aggregate. Aggregation should only be permitted unless and until the number of taglines would require additional pages involving additional cost to the entity. The same should apply for websites – since HHS provides model taglines and a specific webpage of taglines would not have space limitations – all taglines should be included rather than an aggregated number. As the regulation recognizes, if an entity is putting information on a homepage, then the name of the language can be included as a guide with a link to a tagline. But that linked page – such as that used by healthcare.gov[6] – could easily include all disaggregated taglines without eliminating any through aggregation. Given that model taglines are provided by HHS, and that more than 15 taglines could easily fit on one page, we believe HHS should require any entity seeking to aggregate to provide a written justification as to how aggregation would be overly burdensome to the entity. This must be balanced with the need to inform consumers.

In fact, it is because many of the entities covered by this proposed regulation are likely much larger in scope and size than entities generally covered by the Section 1557 final regulations that there should be a greater expectation to provide taglines and language services because these entities have more resources. Given the acknowledged

[6] See https://www.healthcare.gov/language-resource/#french.

difficulties in reaching non-English speaking consumers, and the lack of comprehensive data collection of applicants' and enrollees' language needs, taglines offer one of the least costly methods to help inform LEP individuals of their rights and the availability of in-language assistance.

Further, having different standards for aggregation based on the states an entity serves could create confusion for consumers. For example, a web broker may operate in a different set of states than an issuer and thus have different aggregation results than an issuer. A consumer could get a tagline in her language on a broker's materials but not see the same taglines on her issuer's materials. She may thus wonder if language services are available from the issuer. Keeping requirements for taglines by state will help create uniformity for consumers within that state and preclude questions and confusion about why the taglines differ amongst a variety of documents. The aggregation is much more likely to create differing results for larger entities than may have been anticipated in the Section 1557 regulations where most covered entities likely only operate within one state. That is, the Section 1557 regulations are necessarily broader because of the wider swath of covered entities to which they apply; we believe HHS has the ability and indeed the need to have more specific requirements for situations like the ones covered by this regulation to meet the needs of outreach and enrollment of hard-to-reach populations.

From a practical standpoint, since HHS provides sample taglines and state-by-state data of the top 15 languages, it should not entail significant resources from a covered entity to use them. Additionally, since many entities may comply by creating one webpage or an addendum to written materials with the taglines, space would be the potential legitimate constraint on the number of taglines. Yet more than 15 taglines could easily fit on a one-page addendum or webpage without adding cost or confusion. Given that entities such as issuers or brokers operating in more than one state likely have to tailor materials to the requirements of that state, and thus already create state-specific materials, requiring tailored state-specific taglines would not be an onerous requirement. For example, issuers have to provide notice of appeal rights and disclose the availability of and contact information for any applicable health insurance consumer assistance or ombudsman, which differs from state to state.[7] In Washington, DC, issuers have to list the DC Ombudsman and the Department of Insurance as sources of help for consumers and provide detailed contact information. We should err on the side of over-inclusion rather than under-inclusion to ensure adequate notice of available language services for those who need them.

[7] 45 CFR §147.136(b)(2)(E)(5).

Additionally, we have concerns about aggregation in states that may use the same contractor to operate state-based exchanges. While we recognize the intent might have been to specifically address the FFM, we are concerned that this language could also be read to include a contractor that might contract with a number of states to develop state-based Exchanges. That is, if the same contractor operates Exchanges in, for example, 3 different states, would that contractor be permitted to aggregate LEP data? We would recommend not. While one contractor may work with multiple states, each state has its own unique needs and will likely have different LEP population groups. We do not believe it is the intent of the proposed regulation to allow aggregation in this situation since the impact could seriously reduce notification to LEP consumers. For example, both Connecticut and Maryland have used the same contractor to develop their state-based Exchange platforms. Using HHS' data,[8] Connecticut's top 15 languages are: Spanish, Portuguese, Polish, Chinese, Italian, French, French Creole, Russian, Vietnamese, Arabic, Korean, Albanian, Hindi, Tagalog and Greek. Maryland's top 15 languages are Spanish, Chinese, Korean, Vietnamese, French, Tagalog, Russian, Amharic, Kru/Ibo/Yoruba, Urdu, Persian, French Creole, Portuguese, Arabic and Gujarati.

Language	Maryland	Connecticut	Sum
Spanish	174,142	156,861	331,003
Chinese	29,766	13,409	43,175
Korean	21,344	3,535	24,879
French	12,695	7,501	20,196
Portuguese	3,496	16,008	19,504
Vietnamese	12,905	4,681	17,586
Polish		15,109	15,109
Russian	8,713	4,916	13,629
Tagalog	10,644	2,639	13,283
Italian		10,037	10,037
French Creole	3,854	5,567	9,421
Amharic	7,435		7,435

[8] Appendix A – Top 15 Non-English Languages by State, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Appendix-A-Top-15.pdf.

Arabic	3,363	3,805	7,168
Kru, Ibo, Yoruba	5,605		5,605
Urdu	5,456		5,456
Persian	4,756		4,756
Albanian		3,295	3,295
Gujarati	3,270		3,270
Hindi		2,930	2,930
Greek		2,242	2,242

Allowing aggregation, Maryland's bottom 3 languages would fall off aggregation and Connecticut would lose 2 languages. Two of Maryland's lost languages – Persian and Albanian – had more individuals in Maryland than either state's Arabic population yet allowing aggregation would delete these from the list.

We thus strongly believe that the tagline provisions should remain in these regulations and not merely included as a cross-reference to Section 1557.

RECOMMENDATIONS:

1. Retain specific tagline requirements in § 155.205 rather than merely cross-reference to 42 C.F.R. § 92.8 or omit references.
2. Only allow aggregation if an entity documents that it would be a hardship not to aggregate due to increased costs (recognizing that the entity would not have costs in producing taglines since model taglines are available from HHS).

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

We continue to have concerns about allowing brokers to utilize a direct enrollment pathway that does not provide consumers with an application number or ability to obtain information about their enrollment through healthcare.gov or the Call Center. We have heard from many consumers about enrolling with a broker but then having difficulties when they need to update/change information, reenroll, or conduct other activities regarding their account and do not have an official application number with which to do so. Sometimes brokers engage in unethical behavior and set up a healthcare.gov account and security questions without the consumer's input so the consumer has no way of accessing the account. And sometimes the brokers are unavailable outside of open enrollment and sometimes the brokers do not respond to consumers' requests for

assistance. Thus, we strongly recommend that if HHS is going to allow brokers to utilize a direct or enhanced direct enrollment pathway that his pathway must generate an application number that brokers must be required to provide to consumers. And if a broker sets up a healthcare.gov account for a consumer, brokers must be required to provide access information – including username, password, security questions and answers – to the consumer for future use.

Ideally, the direct enrollment pathway – or the enhanced direct enrollment pathway envisioned by the proposed rule – would also create a healthcare.gov account for consumers assisted by brokers but we also recognize that not all consumers will want, or be able to obtain (due to identity proofing issues), an electronic account. By at least providing an account number, consumers would be able to obtain assistance from sources other than the broker if the broker is unavailable, unresponsive, or goes out of business.

We support the requirement for web-brokers and issuers that use the direct enrollment pathway to differentially display standardized options. However, we oppose the allowance that the manner of display may differ from the HealthCare.gov format. We believe that consumers should have consistency in the way plan options are presented, and this should not vary as between HealthCare.gov and agents, or between two agents, etc. The cost of complying with display requirements is a logical cost of doing (lucrative) business for agents.

Under proposed “enhanced” direct enrollment, consumers would complete on-line enrollment via a third-party website without being transferred to HeatlhCare.gov. As HHS notes in the comment preamble, this raises privacy concerns, and we urge HHS to set minimum standards for security if enhanced direct enrollment is used. We also would recommend against enhanced direct enrollment unless HHS can make certain that the user interface will have the same content (including appearance, organization, formatting, etc.) as the HealthCare.gov layout. It would not “simplify” things for consumers if they had a direct enrollment system that had less information, less accessibility standards, or confusing layouts and presentation of information.

We support the additions at: §§ 155.220(c)(3)(i)(I); 155.220(c)(3)(i)(J); 155.220(c)(3)(i)(K); 155.220(c)(3)(i)(L); 155.220(c)(3)(i)(M); 155.220(c)(3)(i)(E); 155.220(c)(4)(i)(E); and 155.220(j)(2)(i).

We recognize that HHS may need support in conducting monitoring as required by § 155.220(c)(5). We would support such third party arrangements to conduct monitoring

only if HHS develops strong minimum standards for the activities of any designee or contractor.

We recommend that HHS not require direct enrollment with a QHP issuer to be allowed in all SBE-FPs; instead, we believe states should be able to determine whether QHP issuer direct enrollment is permitted.

§ 155.230 General Standards for Exchange Notices

We commend HHS for taking steps over the last several years to strengthen network adequacy protections in the Exchange. 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.[9]

We appreciate that HHS chose to start reporting network breadth as part of the plan selection process for plans in the FFE on a pilot basis starting next year. As we mentioned in our comments to the proposed Benefit and Payment Parameter regulation last year, 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.[10] We remain 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

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[9] *See, e.g.,* ABBI COURSOLLE, NAT'L HEALTH LAW PROG., MEDICAID MANAGED CARE REGULATIONS: NETWORK ADEQUACY & ACCESS (2016), http://www.healthlaw.org/publications//Brief-3-MMC-Final-Reg; Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to J.P. Wieske, Nat'l Assn. Ins. Comm'nrs (Jan. 12, 2015), http://www.healthlaw.org/publications/search-publications/NAICS-Comment; NHELP, NETWORK ADEQUACY LAWS IN COVERED CALIFORNIA PLANS (2014), *available at* http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/network-adequacy-laws-in-covered-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-medicaid-managed-care.

[10] *See, e.g.,* AARON WESOLOWSKI *ET AL*., NORC, ASSESSING THE STATE OF PROVIDER NETWORKS IN FEDERALLY-FACILITATED MARKETPLACES (2016), http://www.norc.org/PDFs/IB_NORCFormat_8%2030%2016.pdf; 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.

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, breadth is not a good measure of choice. In our experience, the fact that a plan contracts with a large number of providers does not mean that consumers actually have access to that full network, but instead the extent of access is heavily mediated by provider capacity and willingness to provide covered services combined with the plan's referral policies and subcontracting relationships. Thus we recommend that HHS closely scrutinize the delegation model and referral practices in plan networks, as well as the extent to which providers are accepting new patients and refuse to provide certain covered services due to moral or religious objections, so that it can make accurate ratings as to the breadth of QHP networks.

We anticipate that the pilot will provide HHS with helpful feedback on the utility of a network breadth indicator, and we applaud HHS's decision to evaluate the results of the initial pilot before expanding to additional states. We recommend that the indicator specifically account for the number of women's health providers included in plan networks, since women's health providers are important providers of preventive services. We agree that to provide meaningful information about networks to consumers, the indicator should distinguish in some way that is clear to consumers between integrated delivery systems and traditionally contracted networks. In our experience, many consumers do not understand the differences between these two types of plans and their implications, so we encourage HHS to develop a clear designation accompanied by a concise explanation. We support HHS's decision to define an integrated delivery system for this purpose consistent with § 156.235(b).

We continue to commend HHS for reminding issuers that they will be subject to additional consumer protections aimed at reducing the incidence of "surprise bills" starting in 2018. We thank HHS for requesting additional feedback as to policy changes that would limit these "surprise bills." We appreciate HHS's attention to this issue, and reiterate our suggestions on how HHS can strengthen these provisions with additional rulemaking to better protect consumers from unfair surprise bills and to ensure that their networks are adequate.

Specifically, we previously noted that 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.

We again 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 continue to urge HHS to prohibit surprise billing practices all together. HHS's allowance of surprise billing as long as a QHP counts the balance billing toward the enrollee's annual limitation on cost-sharing 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. California's recently approved law could serve as a model in this regard.[11] As California has recognized, the promise of network adequacy is significantly compromised by an exclusion that allows consumers to be balance billed by out-of-network providers whom they had no choice not to use.

We repeat our strong recommendation 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. The current rule limits the protection to "ancillary providers," which we worry will be interpreted to offer no protection when consumers receive surprise bills from emergency room doctors or physician specialists. Recent analysis of data from Texas PPO plans by the Center for

[11] A.B. 72 (to be codified at Cal. Health & Safety Code §§ 1371.30-.31, 1371.9 and Cal. Ins. Code §§ 10112.8-.82), http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB72; *see also* JACK HOADLEY *ET AL*., GEORGETOWN CTR. HEALTH INS. REFORMS, BALANCE BILLING: HOW ARE STATES PROTECTING CONSUMERS FROM UNEXPECTED CHARGES? (2015) (describing policies in several states), http://www.statecoverage.org/files/Georgetown_Balance_Billing.pdf.

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.[12] 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 again 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 change course, and require issuers to provide notice to consumers far enough in advance to allow consumers to make other arrangements. The 48 hour notice period provided for in the rule is not adequate to allow consumers to find another provider to avoid surprise bills. Moreover, HHS should issue clarification that QHP issuers may ***not*** comply with this section by simply providing a form notice to consumers.[13] 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. HHS's allowing issuers to provide only form notice two days before a procedures fails to provide consumers with any real assurance of network adequacy.

Finally, we again note that the provision as written does nothing to protect consumers from balance billed amounts related to services provided at out-of-network facilities.

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[12] 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.

[13] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12204, 12305 (Mar. 8, 2016) (preamble language).

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: Amend § 156.230(e) as follows:

> *Out-of-network cost sharing.* Beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP that uses a provider network***, including a tiered network,*** must:
>
> (1) Notwithstanding § 156.130(c), c~~ount the~~***ensure that any*** cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network ~~ancillary~~ provider in an in-network setting***, 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~~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 ~~by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours~~ ***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.***

Finally, over the past several years, we have recommended that HHS further strengthen exchange network adequacy standards in the following ways:

- Apply the same standards to all Exchanges, including State-Based Exchanges;

- Ensure that Exchanges are required to show that their networks are adequate in the lowest-cost tier;
- Require issuers to include more details (like office hours and language capacity) in their provider directories;
- Promulgate specific minimum standards in regulation for geographic access, timely access, provider-to-covered person ratios;
- Clarify that issuers must provide access to services out-of-network when their networks are inadequate, or as needed to ensure continuity of care in a variety of circumstances;
- Specify that issuers are responsible for ensuring access to limited English speaking enrollees and enrollees with disabilities;
- Develop a robust method of monitoring access and enforcing compliance when necessary; and
- Strengthen protections against surprise bills.[14]

We will not repeat our specific recommendations in detail here. But we again urge HHS to consider making improvements to the regulation in the areas listed above, and offer our assistance to HHS if it opts to undertake additional changes or rulemaking.

We also support the comments of the Consortium for Citizens with Disabilities regarding the form and manner of sending notices.

§ 155.330 – Eligibility Determination During a Benefit Year

We appreciate recognition that the current processes for determining whether consumers have complied with requirements to file taxes and reconcile APTCs has caused some problems for consumers, particularly due to delays between filing taxes and processing by IRS. Thus, we support the options provided in the proposed rule to grant more flexibility to Exchanges to determine how continue enrollment if confirmation

[14] *See* Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Andy Slavitt, Ctrs. for Medicare & Medicaid Servs. (Jan. 15, 2016) (comments on HHS Letter to Issuers for 2017), http://www.healthlaw.org/publications/Comments-Draft-2017-Letter; Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Andy Slavitt, Ctrs. for Medicare & Medicaid Servs. (Dec. 21, 2015) (comments on HHS Notice of Benefit and Payment Parameters for 2017), http://www.healthlaw.org/publications/2017-Parameters; Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Kevin Counihan, Ctrs. for Medicare & Medicaid Servs. (Jan. 12, 2015) (comments on HHS Letter to Issuers for 2016), http://www.healthlaw.org/publications/Letter-Draft-Letter-to-Federally-facilitated-Marketplaces-Issues; Letter from Elizabeth G. Taylor, Nat'l Health Law Prog., to Ctrs. for Medicare & Medicaid Servs. (Dec. 22, 2014) (comments on HHS Notice of Benefit and Payment Parameters for 2016), http://www.healthlaw.org/publications/nhelp-comments-notice-of-benefit-and-payment-parameters.

from IRS is not available. For example, if a consumer can submit a copy of a filed tax return, this could assist in maintaining enrollment or allowing reenrollment despite a time lag between receipt by IRS and availability of electronic confirmation of receipt to the Exchange.

§ 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 ATPCs, 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.

§ 155.420 – Special enrollment periods

We appreciate the codification of the Special Enrollment Periods (SEPs) outlined in the propose rule, including for dependents of Indians; domestic abuse or spousal abandonment; consumers who apply for coverage and are later determined ineligible for Medicaid or CHIP; material plan or benefit display errors; resolving a data matching issue after expiration of an inconsistency period.

We are also extremely concerned about other efforts to limit SEPs. We have heard concerns that some consumers may be signing up for coverage only when they are sick. But given the rules governing SEPs, as well as the new post-eligibility verification processes, we believe that many more eligible consumers are actually deterred from applying for SEPs as opposed to problems with ineligible consumers obtaining coverage.

We strongly believe that HHS must undertake a comprehensive evaluation of the SEP process to identify whether misuse has occurred and identify the appropriate methods of addressing this without burdening eligible consumers and deterring SEP applications from healthier consumers which can impact the risk pool. For example, now that HHS has required post-eligibility verification for most of 2016, HHS should investigate:

- How many consumers applied for SEPs?
- How many consumers started but did not finish an SEP application?
- How many consumers provided documentation of eligibility?
- For those who did not finish an application or did not provide documentation, what were the reasons why? (This would necessitate direct follow-up with consumers.)
- How many consumers were granted SEPs? What percentage?
- How many consumers were denied SEPs? What percentage?
- What were the reasons for the denials?
- What were the financial costs to the FFM to implement verification?
- If an SEP was denied, did consumers apply for a different SEP?
- How many SEP denials were appealed? What was the result of those appeals?
- What was the experience of assisters helping consumers through the verification process?
- What is the balance of "costs" (not merely financial) to consumers (in terms of the burdens of providing documents and loss of coverage) versus the benefits of restricting SEP eligibility?
- If insurers allege that the SEP process is subject to fraud, what is the evidence for this allegation?
- If insurers allege that consumers enrolling through SEPs are more likely to drop coverage, what is the evidence of this? And why are these consumers dropping coverage?
- What other options might there be instead of verification to achieve the same or similar results without burdening consumers with verification?

We also believe that other solutions – such as adjusting payments to issuers to recognize the potential of higher costs for mid-year enrollees – would be a more effective solution as opposed to erecting higher barriers for consumers to obtain SEPs.

§ 155.430 – Termination of exchange enrollment or coverage

We support inclusion of the requirements regarding rescission such that an issuer must demonstrate that the rescission is appropriate. It is essential that consumer's rights be

protected in this situation and that issuers should not be permitted to rescind coverage without a demonstration of actual fraud by the consumer.

§ 155.505 – General Eligibility Appeals

We are concerned that the proposed rule seems to envision a paper-based process for appeals for the foreseeable future. We recognize the complexity of implementing complex processes but we believe the proposal will remove any motivation to plan for and implement an electronic appeals system. We strongly believe that HHS should set clear and firm deadlines by which an entity must meet existing electronic requirements.

Having a paper-based appeals process necessarily breeds inefficiencies as paper appeals requests are ultimately entered into a database for tracking. Thus, time and resources are wasted in the receipt, logging, and data entry of an appeal request. Limited resources should instead be utilized to decide and effectuate appeals.

Given that the appeals process for the FFM already takes significant periods of time from filing to resolution to effectuation, all efforts must be undertaken to streamline and automate this process to benefit consumers who many be without coverage or without tax credits and cost-sharing assistance while appeals are pending. Efforts must be undertaken to increase the resources for appeals to comply with the regulatory time periods for processing. We have heard of many examples of appeals and implementation taking months longer than the regulation expects or even years. Consumers are in limbo and many of them incur significant financial hardships during tis process. Some consumers have been denied care by providers who are not paid because a consumer is appealing a denial of tax credits, some consumers have had medical debt sent to collections and have had reductions in their credit scores while awaiting the outcome of an appeal. And once a favorable decision is reached, many consumers have difficulty obtaining efficient implementation of an appeals decision due to systems limitations and then have to negotiate with their issuers to secure back coverage, submit claims and obtain reimbursement.

An electronic system would hopefully include a tracking system to ensure timely processing of appeals. We continue to hear from advocates that they have to call continuously to get status updates on their appeals cases and continually follow up to request informal and formal hearings. As one example, an advocate worked with a consumer to file an appeal in June 2015. The consumer never received written acknowledgement it was received. Over the next 8 months, the advocate received different answers on its status from the Appeals Center, ranging from an informal resolution letter was generated and mailed to no action had been yet taken. As another

example, one legal advocate had a case that took 6 months for the appeal center to schedule a hearing. The consumer received a favorable decision in Feb 2016. But the appeals center and marketplace were unable to implement retroactive coverage for the consumer because the delays resulted in a change into a different plan year than the current year. After 5 calls to the appeal center and multiple escalations, the retroactive coverage was finally granted a year after appeal began. Further, advocates point to difficulties in implementing appeals because the appeals center does not have the electronic functioning to implement appeal decisions. Thus, the appeals center has to transfer information to the marketplace and advocates often have significant challenges ensuring implementation becomes effective. These examples point to the dire need to have an electronic system of filing, tracking, and implementing appeals.

At the very least, an Exchange should be able to receive information via email if it cannot implement a fully operational web-based appeals process. That is, an appeals entity could easily create a fillable PDF of its appeals request form and open an email address to accept appeals. This would alleviate many of the issues with a paper-based appeals system since an individual could get an immediate acknowledgment of receipt, could attach relevant documents, would not have to travel or pay for the costs of postage, and could expedite receipt and processing of an appeal request. Under current practice, the consumer bears the burden of an entity's noncompliance.

Further, we are concerned about the seeming failure to accept the application date as the effective date for coverage after an appeal resolution. When individuals apply for coverage and perhaps are unable to obtain an eligibility determination due to a data matching issue, the consumer must then provide supplemental documentation confirming the individual's residency, citizenship status, immigration status and/or income. Particularly for immigrants, for whom coverage is not provided during resolution of the data matching issue, a final determination of eligibility, particularly if upheld on appeal, should allow the individual to enroll in coverage effective to the application date and not the resolution of the data matching issue. That is, regardless of how long it takes to resolve the data matching issue and, if necessary, an appeal, the original application date should still be available to a consumer once the issue is resolved. While a consumer should have the choice of using the application date or only obtaining prospective coverage, it seems that HHS has recently foreclosed the use of the application date, particularly for some immigrants. A recent appeal decision upheld this decision. The facts of the case were a consumer with a U visa who submitted her immigrant document numbers upon application but was determined potentially eligible for Medicaid. The consumer then obtained a Medicaid denial and was determined prospectively eligible for coverage. However, the consumer sought coverage back to the application date via an appeal. The appeal decision denied using the application

date and upheld the Exchange's determination of prospective coverage. This is extremely troubling since the individual was actually eligible from her date of application but because the federally facilitated marketplace has failed to implement all steps of the SAVE system to check immigrant eligibility, the consumer had to jump through additional barriers of obtaining a Medicaid denial and submitting immigration documents. These steps – not due to her inactivity but rather the technological limitations of the Exchange – led to a delay in coverage. Once eligibility was established, she should have been given the option of coverage back to her application date. In this particular case, she incurred medical bills and would have elected this coverage. Many more individuals – immigrants and others – are found initially eligible due to systems limitations rather than actual ineligibility and the Exchange should not compound its limitations by then denying coverage while the eligibility is being evaluated. While our comments here are about the appeals systems, we strongly recommend that the questions on healthcare.gov regarding immigrant eligibility must be addressed quickly so that more immigrants do not fall prey to the systems limitations that unnecessarily deny them immediate coverage. And if these individuals then have to go through the appeals process – further denying coverage – a decision in favor of the consumer must be implemented in a manner that makes the consumer whole rather than perpetuates the disparate treatment of immigrants.

That is, merely because the eligibility determination was made at a later date does not negate the original application date since the consumer was eligible initially but systems limitations prevented her from obtaining immediate coverage. Consumers who are only provided prospective coverage could incur significant financial hardship if the effective date is not the original application date.

We also reiterate concerns that continue from our comments on last year's proposed rule. Our understanding is 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.[15]

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

[15] 42 U.S.C. § 18081(f) (emphasis added).

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 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.

§ 155.555 – Employer Appeals Process

For the reasons outlined in our comments on § 155.505, we are similarly concerned with a paper-based appeals process for employers. We believe a paper-based system is inefficient and can cause unnecessarily delays in the appeals process which harms consumers.

§ 156.200 – QHP issuer participation standards

We strongly support HHS's interpretation of ACA § 1301(a)(1)(C)(ii), namely that the ACA "did not intend to allow an issuer to offer a silver and gold QHP through the Exchange in merely one service area in a State, while offering other products through the Exchange, such as bronze or catastrophic QHPs, in other service areas." We support the modification of § 156.200(c)(1) to require coverage of both a silver and gold plan throughout the service area.

§ 156.235 – Essential Community Providers

NHeLP continues to commend HHS's efforts to strengthen the Essential Community Provider (ECP) standard and address concerns safety-net providers have raised. The requirement that QHP networks must contract with ECPs who provide care to predominately low-income and medically-underserved populations is key 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 continue to 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. 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. We ask again that HHS

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. We urge HHS to 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 ask that HHS explicitly allow states to adopt more protective state-specific ECP and network adequacy standards for QHPs in the state.

RECOMMENDATION: Amend § 156.235(a)(2) as follows:

> A plan applying for QHP certification to be offered through a***n*** ~~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)

As we mentioned in our comments to the proposed Benefit and Payment Parameters regulation last year, we oppose HHS's proposal to count multiple providers at one location separately.

We are disappointed by HHS's proposal to continue 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. This calculation method dilutes 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. Continuing the practice 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: Revert to the prior version of these sections in effect before May 8, 2016.

c. § 156.235(a)(2)(i)

We continue to support the requirement 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: Amend § 156.235(a)(2)(i) as follows:

> The network includes as participating providers at least ~~a minimum~~ ***30*** percent~~age~~, 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. 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 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. This requirement is particularly prescient due to the fact that under the Final 2017 Letter to Issuers, 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, except for terms that would not be applicable to an ECP, such as by virtue of the type of services that an ECP providers." 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.

RECOMMENDATION: 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: Eliminate §§ 156.235(a)(3) and 156.235(b)(3).

Beyond 2018, in regards to the best approach for measuring hospital participation for the 2019 benefit year, we are concerned that the number of reported hospital beds is a not reliable proxy for consumer access. We recommend that the Department assess how hospital beds are situated within the hospital or practice and how hospital beds serve an ECP role. For instance, the Department should consider how many staffed hospital beds serve each of the ECP categories of services (e.g. family planning, HIV treatment, Indian Health Services) – similar to how the Department designed the alternative ECP standard – and how many hospital beds actually serve low-income and medically underserved individuals. Additionally, the Department should monitor how many hospital beds reside in each department (e.g. intensive care unit compared to maternity) to achieve a better sense of true capacity to serve the needs of low-income and medically underserved individuals. With many outstanding questions regarding how the new counting methodology will impact consumer access to ECPs, we request that the Department clearly outlines the proposed methodology for calculating QHPs' satisfaction of the ECP inclusion standard and meaningfully solicits the ECP stakeholder community's input on the methodology.

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 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: 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. § 156.235(c)

We thank HHS for responding to stakeholder comments in the 2016 Benefit and Payment Parameters rule and incorporating into regulation at 45 C.F.R. § 156.235(c) that ECPs include state-owned, governmental, and not-for-profit family planning service sites that do not receive Title X funds or other 340B-qualifying funds. This is an important step in implementing the clear intent of ACA section 1311(c)(1)(C), which Congress designed to protect access to women's health providers in addition to other ECPs. To further clarify this point, we ask that HHS make a technical correction to the ECP definition in 45 C.F.R. § 156.235(c) to specify that providers described in § 1927(c)(1)(D)(i)(IV) of the Social Security Act ***include*** nonprofit and governmental family planning service sites that do not receive Title X or 340B-qualifying funding.

The ECP definition text at 45 C.F.R. § 156.235(c) does not clarify what the Department clearly intended to clarify based on preamble language, and the regulatory text must be amended to prevent any unintended implications for family planning ECPs. In its current form, this definition clarifies that family planning providers that do not participate in Title X or 340B are considered ECPs but erroneously excludes these providers from the providers captured by § 1927(c)(1)(D)(i)(IV) of the Social Security Act. In effect, the use of term "or" instead of "including" inadvertently and unnecessarily creates a new type of non-340B family planning providers. Not only does this contradict congressional intent and what the Department clearly meant in preamble text in the 2016 Notice of Benefits and Payment Parameters final rule, it creates needless confusion and may have harmful implications for family planning providers. For these reasons, we recommend that the Department make a minor technical correction to resolve the accidental oversight.

RECOMMENDATION: Make a technical correction to § 156.235(c) as follows:

> (c) *Definition*. An essential community provider is a provider that serves predominantly low-income, medically underserved individuals, including a health care provider defined in section 340B(a)(4) of the PHS Act; or described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Pub. L. 111-8; ~~**or**~~ ***including*** a State-owned family planning service site, or governmental family planning service site, or not-for-profit family planning service site that does not receive ***340B-qualifying funding*** ~~**Federal funding under special programs**~~, including under Title X of the PHS Act, or an Indian health care provider.

§ 156.265 – Enrollment process for qualified individuals

As per our comment to § 155.220, we support the requirement of differential display of standardized options for agents and brokers using direct enrollment processes, but we oppose the creation of any "deviation" from that display approvable by HHS.

§ 156.272 – Issuer participation for full plan year

We support the inclusion of this provision. We also believe it should apply to all Exchanges as we do not believe consumers in non-FFEs should have different results about full year availability merely based on where they live.

§ 156.290 – Non-certification and decertification of QHPs

We support the requirement that a QHP must notify its enrollees when it is not certified for a subsequent, consecutive certification cycle. To maintain consistency with other deadlines and to promote clarity, we recommend that the regulation be updated to specify calendar days.

RECOMMENDATION: Update § 156.290(b)(2) to say "…must provide written notice to each enrollee within 30 *calendar* days…."

§ 156.715 – Compliance reviews of QHP issuer in Federally-facilitated Exchanges

Compliance reviews serve an important role in ensuring that issuers meet EHB and other standards. NHeLP strongly supports strengthening the compliance review process by allowing for sanctions on issuers that are non-responsive or uncooperative with the compliance reviews.

However, we have continuing concerns regarding the lack of transparency in the issuer monitoring and review process. We urge HHS to make the results of its compliance reviews publicly available on an ongoing basis rather than posting a year-end summary report, as described in the final 2017 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 29, 2016) at 59. Health care consumers and advocates could greatly benefit from more detailed information revealed by compliance reviews when assessing plan performance, including issuers and plans subject to targeted, expedited reviews when CCIIO has identified potential harm to consumers. We also urge HHS to also conduct randomized reviews of plans to identify issues or deficiencies that may not be captured by the risk-based analysis.

§ 156.1230 – Direct enrollment with the QHP issuer in a manner considered to be through the Exchange

We support the requirement that QHPs must notify consumers with information about the FFE, other QHPs offered on the FFE, and insurance affordability program. In particular, we commend the inclusion of requirements to prohibit misleading, coercive, or discriminatory content. We recommend revising the rule to require that the information QHPs give to consumers in this context must be provided to promote meaningful access to persons with disabilities and/or limited-English proficiency in accordance with 45 C.F.R. §§ 92.201, 92.202.
Please see our comments regarding the direct enrollment pathway for brokers under § 155.220. Our same concerns arise regarding issuer direct enrolment as with broker direct enrollment.

RECOMMENDATION:

- Require that information to consumers in such a way to promote meaningful access to persons with disabilities and/or limited-English proficiency.
- Include references to 45 C.F.R. §§ 92.201, 92.202 in § 156.1230(b)(3)

§ 158.232 – Calculating the Credibility Adjustment and § 158.240 – Rebating Premium if the Applicable Medical Loss Ratio Standard is Not Met

We are supportive of requirements to smooth out the impact of MLR calculations in early years to reduce barriers to entry of issuers into the market or expansion by current issuers. We support this approach to the extent that, as we understand it, the payments would be equivalent in the long-term, but some of the early year volatility would be reduced.

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