COMMENTS to the Department of Health and Human Services and Centers for Medicare & Medicaid Services

RE: HHS Notice of Benefit and Payment Parameters for 2016
Submitted by Community Catalyst
December 22, 2014

Community Catalyst respectfully submits the following comments to the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) in response to the HHS Notice of Benefit and Payment Parameters for 2016, released November 21st.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone - especially vulnerable members of society.

We greatly appreciate the opportunity to provide comments on the proposed regulations that give insurers, states and consumers helpful guidance about how Marketplaces will serve consumers going forward. The proposed regulations include many important steps forward for consumers. We applaud HHS for strengthening consumer protections in the proposed regulations, especially in revisiting benchmark plan choices, rate review, and network adequacy standards, and in increasing transparency and data collection overall. In addition, there are a number of areas the regulations could be further improved to support consumer access to high quality health care. We focus our comments both on the advancements these proposed regulations create for consumers as well as areas where they could still be strengthened.

Part 144

§ 144.103 – Definitions

We support CMS's proposed change in definition of 'plan' to mean the pairing of health coverage benefits under the product with a particular cost-sharing structure, provider network and service area. This proposed definition of plan more closely aligns with plan coverage experienced by consumers and is especially important as applied in the context of the rate review provisions proposed in this rule and outlined below.

Part 154

§ 154.200 – Rate Increases Subject to Review

We strongly support CMS's proposal to require the state or CMS to consider rate increases at the plan level instead of the product level when determining whether an increase is subject to a review. Because consumers are affected by rate increases at the plan level, we think it is appropriate for the plan, not the product, to trigger the applicable review. This proposed change is an important step to protect consumers from unreasonable rate increases.

§ 154.220 – Timing of Providing the Rate Filing Justification

We strongly support CMS's proposal to establish a uniform timeline by which insurers must submit completed rate filing justification to CMS or the state, whichever applicable. Establishing a uniform timeline will increase transparency and, while dependent on state adherence to the timeline, add a level of predictability that will help to increase awareness about the rate review process and public comment periods. Rate review has not been a topic that has historically received a great deal of public participation, and we believe that moving toward more uniformity in the markets across state lines will help increase public understanding and ability to comment on the rate review process.

§ 154.301 – CMS's Determinations of Effective Rate Review Programs

We applaud CMS's proposal to increase transparency requirements for states to meet the criteria for an effective rate review program. Public access to information about proposed and final rate increases with a mechanism for public comment is crucial to helping consumers understand rates. While the proposal takes important steps to ensure consumers have access to proposed and final rate increases, **we recommend adding the following requirements for an effective rate review program:**

- **A sixty-day comment period on proposed rate increases**
- **Consumer friendly rate summaries accessible from the state's website and posted within the timeframe for proposed rate increases**

Additionally, we believe that that information on final rate increases should be available prior to the start of the first day of the annual open enrollment period. **We recommend that final rate increases should be made available at least 15 days prior to the start of the annual open enrollment period.** This will allow consumers and enrollment assisters to become more familiar with the premium rates, which will lead to more informed choices when it comes time to pick a plan that is right for the consumer.

Part 155

§ 155.205 – Consumer Assistance Tools and Programs of an Exchange

Community Catalyst recommends that the proposed regulation include a requirement of written translations in the languages spoken by the applicable state's top ten Limited English Proficiency (LEP) groups or spoken by 10,000 persons or greater, whichever yields the greater number of languages as well as oral interpretation in as many languages as are generally available by telephonic interpreter services (which we understand is at least 150 languages). It is commendable that these proposed regulations include the requirement that

Exchanges, QHP issuers and web-brokers provide oral interpretation services over the telephone in at least 150 languages. This will provide a standard for these entities to provide all information that is critical for obtaining health insurance and accessing health care services in languages for those individuals with limited English proficiency. However, we believe our recommendation will further enhance the experience those individuals with limited English proficiency. Additionally, we support requiring that website content be translated in each non-English language spoken by an LEP population that reaches 10 percent of the state population.

§ 155.215 – Establishment Grant

Community Catalyst thanks CMS for clarifying section 155.215 (h) by changing "assistance personnel" to "entities." This allows for individual non-Navigators to help consumers in the best way possible, whether that is over the phone for rural outreach or in person for those in more populated areas. We worry that if a non-Navigator individual is not associated with a larger entity, the requirement to be physically present where they are helping consumers will limit their ability to help in more remote areas.

§ 155.335 – Annual Eligibility Redetermination

We applaud CMS for considering alternative re-enrollment hierarchies with a focus on what might be most important to consumers. **However, while we know that low-premium plans are important to many consumers, we are concerned that defaulting to the lowest cost plan will have negative consequences on network adequacy and market competition.** Because the lowest cost plans often correspond with the narrowest networks on the Marketplace, we are concerned that consumers will opt into this re-enrollment option because of the premium implications and end up with a plan that does not have a network of providers to adequately address their needs or with cost-sharing that substantially increases their out-of-pocket costs. Therefore, we believe that consumers must be informed about how their re-enrollment choices might impact their coverage, and we urge CMS to consider the following:

- During open enrollment when a consumer has the option to opt into a re-enrollment hierarchy, they should receive notice of what each option means in terms of the potential for higher out-of-pocket costs and changes to provider networks.
- When Marketplace and issuer notices are issued with instructions for upcoming renewal and open enrollment deadlines, the consumer should be notified of which hierarchy they chose during open enrollment and how that default re-enrollment plan differs from their current plan.
- All notices should make clear that the consumer has the option to change plans during the open enrollment period with instructions on how to do so.

Based on our experience in Massachusetts outlined below, we recommend that if CMS decides to move forward with the proposed re-enrollment hierarchy, then consumers who chose the option to default to the lowest premium plan should be assigned to at least the four lowest cost plans in the service area with 40% in the lowest cost plan, 30% in the second lowest cost plan, 20% in the third lowest cost plan and 10% in the fourth lowest cost plan in order to increase market competition. Additionally, we urge CMS to include at

least a 30-day grace period to switch plans if a consumer finds that the plan is not adequate to meet their health needs.

The 2006 Massachusetts health reform law created the Commonwealth Care subsidized health insurance program. The program was managed by the state's exchange, the Health Connector. The Connector accepted bids from five managed care companies to provide coverage to members of the program. Members below 150% of poverty had no premium, while those above that level had sliding scale premiums.

Initially, Massachusetts auto-enrolled non-premium paying members who did not select a managed care plan into the lowest-cost plan for their region. The Connector hoped that the reward of getting auto-enrolled members would spur plans to bid as low as possible. It would also save the Connector money.

By the second or third year, the Connector saw that plans that had no reasonable likelihood of being the lowest-cost plan had no incentive to try to submit an aggressive bid. So the Connector altered their auto-assignment methodology. Initially, the lowest bidding plan would get 75% of the auto-renewed members, and the second-lowest would get the remaining 25%. In later years they altered this further, to give some auto-assigned members to the third- and even fourth-lowest plan.

Finally, we recommend that CMS continues to make improvements to the current re-enrollment process in place for the 2015 plan year. In particular, we urge CMS to update eligibility determinations for individuals who choose to automatically renew their plans. This will ensure that consumers are receiving the correct amount of financial assistance, and will alleviate the concern that an individual is automatically renewed in a plan with a premium that they are unable to afford. CMS should rely on the experiences of states operating state based marketplaces, such as Colorado, Kentucky and California, that chose to adjust premium tax credits for 2015 with available premium, age and federal poverty level guideline date during this first round of automatic renewals.

§ 155.410 – Annual Open Enrollment Period

In general, we support the justifications for amending the dates of the annual open enrollment period for benefit years beginning on or after January 1, 2016 so that it begins and ends in 2015, rather than beginning in 2015 and ending in 2016. We agree that amending the dates in this way would likely reduce consumer confusion regarding effective dates of coverage, because all coverage would be effective January 1 of the following year. Also, amending the dates to begin and end in the same year would more closely align with employer plan open enrollment periods, which would allow consumers to compare plan choices.

However, we recommend that CMS extend the dates of the annual open enrollment period for benefit years beginning on or after January 1, 2016, to begin September 15, 2015 but still end on December 15, 2015. Extending the open enrollment period in this way would allow consumers more time to review their Exchange coverage options thoroughly, and would also give consumers more opportunities to obtain enrollment assistance. In addition, a longer open

enrollment period would provide enrollment assisters more time to advertise their services and conduct outreach. Since funding for enrollment assisters is limited, and therefore restricts the amount of consumers enrollment assisters can help, extending the open enrollment period would provide assisters with more opportunities to work with consumers, which would provide more opportunities for consumers to successfully enroll.

Alternatively, at the very least, we recommend that consumers have the opportunity to preview and compare plans starting on September 15, 2015 even if they can't yet enroll. While we agree with CMS that some consumers may be more familiar with the Exchanges at this time, and therefore may not need an open enrollment period as long as previous years, the opportunity to compare plans before the start of open enrollment would allow consumers more time to make informed coverage decisions.

§ 155.420 – Special Enrollment Periods

Working with dozens of Certified Application Counselors to assist consumers with enrollment has shown us that regulatory flexibility is necessary to prevent both gaps in coverage, and economic waste. Predictable or not, normal changes in consumers' lives or employment can cause them to transition from ESI or other coverage to the Marketplace. Allowing flexibility around Special Enrollment Periods, advanced access to special enrollment periods, and reasonable 'coverage effective dates' will help ensure that consumers and their dependents can rely on access to Marketplace options for coverage.

Based on these overall concerns, we strongly support the proposed amendments to section 45 CFR §155.420, with some minor modifications, as a means to prevent gaps in coverage, interruptions in care, and wasteful duplicative coverage.

We strongly support the proposed amendment to section §155.420(d)(6)(iv) allowing a SEP for consumers gaining eligibility in Medicaid non-expansion states. We strongly support the amendment adding subsection §155.420 (d)(6)(iv). This proposed provision would provide vital opportunities for consumers who experience an increase in income to provide coverage for themselves and their families. Creating this opportunity for special enrollment will help allow more consumers to participate in the exchanges when their economic situations change.

We support, with modification, the proposed amendment to §155.420(b)(2)(v) and §155.420(d)(2)(i), allowing a SEP upon gaining a dependent through a child support order. We support the amendment to allow a SEP in response to gaining a dependent through a "child support or other court order", such as a Qualified Medical Child Support Order, bringing these Marketplace rules in line with existing ERISA regulations. We also support the allowance of some flexibility for a 'coverage effective date' under proposed subsection §155.420(b)(2)(v). However, we also note that in some cases, financially vulnerable family members turn to state-based child support enforcement agencies, rather than judicial courts, in order to secure financial and other support. ERISA rules recognize orders by such specialized state agencies as appropriate grounds to allow non-custodial parents the right to a SEP.[1] **We recommend that the**

[1] Dept. of Labor website, Frequently Asked Question Q1-4, clarifying that under ERISA section 609(a)(2), SEP must be granted by a group plan upon receiving "[a]ny judgment, decree, or order that is issued by a court of

final rules, or guidance thereunder, make clear that any "Qualified Medical Child Support Order" duly issued by an appropriate state agency would also qualify an individual for this SEP under §155.420(d)(2)(i).

We support, with modification, the proposed amendment to section §155.420(d)(2)(ii), allowing a SEP upon the loss of a dependent, or upon becoming no longer a covered dependent upon a divorce or legal separation. A custodial parent that is enrolled in a QHP could end up losing a dependent as a result of a qualified medical support order issued by a court or enforcement agency. Such a consumer would obviously want the flexibility to re-evaluate and revise their Marketplace coverage choices, given the differences in costs and coverage options between family and individual plans. **We suggest that proposed section §155.420 (d)(2)(ii) be further modified to include the loss of a dependent as a result of such a court order or qualified medical support order.**

We support, with minor modification, the proposed amendment to section §155.420(b)(2)(ii), allowing consumer discretion to choose retroactive coverage effective date or regular effective date upon the death of a consumer or their dependent. We support this proposed amendment's greater flexibility for coverage effective dates, such as a retro-active start upon the date of a death. This is important because consumers dealing with the death of a family member may need time and flexibility to review and evaluate their options, and choose between QHPs and other coverage options, such as COBRA or other mini-COBRA continuation-of-benefit options under state law. Similar to the concerns we raise below regarding the choice between a coverage gap and duplicative coverage under proposed subsection §155.420(b)(2)(i), there are circumstances where proposed subsection (d)(2)(i) [re consumers losing coverage due to no longer being considered a dependent, such as divorce or legal separation] may also cause consumers to face such a choice. To the extent that this could be avoided, **we recommend listing "(d)(2)" in section §155.420(b)(2)(iii).** This would allow the Exchange the discretion to choose an alternative 'coverage effective date' that coincides with the date that any other existing coverage may end, preventing economic waste.

We strongly support the proposed amendment to section §155.420(d)(1)(ii), allowing a SEP when a group plan expires/renews outside of OE. We strongly support the proposed amendment to subsection (d)(1)(ii), based on numerous inquiries from consumers seeking QHP enrollment options when their group plan (ESI) renews outside of Open Enrollment. Having received other consumer comments about the high costs of some ESI plans that cover families, the proposed amendment is valuable to consumers, because it would allow them the option to shop for options in the Marketplace that may be competitive with their current offers of ESI. This would include instances an ESI plan becomes more restrictive in terms of access to providers or services.

We recommend an alternative approach to proposed amendment to §155.420 (b)(2)(i) allowing alternate coverage effective date upon gaining a dependent through birth or adoption. This proposed amendment would allow consumers using a SEP for the birth or adoption of a child to choose a 'coverage effective date' of either the date of their birth or

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competent jurisdiction or an administrative agency authorized to issue child support orders under State law (such as a State child support enforcement agency)...." Available at http://www.dol.gov/ebsa/publications/qmcso.html.

adoption, or the regular coverage effective date for a SEP (i.e. the first day of the following month for sign-ups before the 16th, and the first day of the second following month for sign-ups after the 15th.) This amendment replaces the existing regulatory text that could allow a consumer to select a coverage effective date of the date of the birth, or the first month after the date of the birth. We agree with the spirit of this change – allowing consumers greater flexibility to select when new QHP coverage begins. However, we feel that this amendment does not go far enough. Consumers who are facing the challenges of integrating a new child into their lives may reasonably choose to change their work schedules, and some may choose to stop working. We have also heard from consumers that family plans available through ESI can be very expensive, costing more than the options consumers can find in the Marketplace.

To prevent difficult situations – such as forcing consumers to choose between paying for duplicative coverage or risking a coverage gap – **we recommend that consumers with existing coverage who then join a QHP with a SEP for gaining a dependent should receive the same flexibility concerning the appropriate 'coverage effective date' that the Marketplace provides under section 155.420(b)(2)(iii).** Therefore we recommend that section 155.420(b)(2)(iii) is amended to include "(d)(2)" before the current text starting "(d)(4), (d)(5)," etc.

We support the proposed amendments to §155.420(b)(2)(iv) and §155.420 (c)(2), allowing advanced selection of a QHP in anticipation of a permanent move, with minor changes. We support this proposal, and the earlier rule changes allowing consumers the opportunity for 'advanced selection' meaning the opportunity to enroll in a QHP prior to a triggering event with an appropriate coverage effective date. These earlier changes have been a valuable administrative response to the experiences of consumers who have previously been forced to wait for triggering events before working with CACs to review and select a QHP. Allowing for advance enrollment in the context of an anticipated permanent move is a good addition to subsection 155.420(c)(2).

In addition, we also support the proposed amendment under subsection §155.420(b)(2)(iv) that would allow such coverage to become effective more quickly for consumers who make a permanent move. However, the conditional language about "plan selection . . . made after *the loss of coverage*" may create some future ambiguity when it is applied to consumers using a SEP related to a permanent move. **We suggest the text under subsection (b)(2)(iv) be further amended to read "after the loss of coverage or other triggering event.."** This suggested modification may also prevent future ambiguity, saving time and effort by consumers, the Call Center, and the Certified Application Counsellors in the field.

We support, with minor modification, the proposed amendment to section §155.420(d)(4), allowing a SEP in response to errors by non-exchange personnel. We support combining existing sections (d)(4) and (d)(10) so as to allow a SEP for an "enrollment or non-enrollment in a QHP" that results from an "error" or "misrepresentation" by "a non-Exchange entity providing enrollment assistance or conducting enrollment activities." This change will provide the Exchange, and thus consumers, more options to correct enrollment errors or mistakes wherever they occur.

However, we suggest that it would be advisable to keep the additional language in existing subsection (d)(4) which allows the Exchange the latitude to take corrective action beyond simply allowing the consumer a SEP. This current regulatory text, which is deleted in the proposed amendment, is as follows:

> "In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;"

See 45 CFR §155.420(d)(4)(2014), as of Dec. 15, 2014. For instance, the authority of the Exchange to take such action could include providing an erroneously miss-enrolled or non-enrolled consumer with restitution or retroactive coverage, as appropriate.

Also, Community Catalyst recommends that the final rule clearly state that the special enrollment period for those making a permanent move applies to qualified individuals leaving incarceration who submit applications via the marketplace <u>prior</u> to their release, and that their coverage will begin on the first day of the month following their release.

Previous regulations specify that leaving incarceration is a considered a permanent move. However, there have been problems with continuity of care for individuals leaving jails and prisons, many of whom have mental illness and substance use disorders. For these individuals, the gap in coverage as they establish their permanent move back into the community can lead to relapse and re-offending. The proposed rule would allow individuals facing a permanent move advanced access to the special enrollment period. Adding language that applies this policy to incarcerated individuals would yield health, safety and financial benefits to society and the states.

<u>Part 156</u>

We support the ability of states to make a new EHB benchmark selection for 2017 and encourage CMS to consider an earlier opportunity to alter state selections. Many current benchmark plans have fallen short and require improvements. **We recommend that CMS require states to have an open process with public input in selecting their benchmark plan. In addition, CMS should document the evaluation process for EHBs, including the criteria used to evaluate them, clarification of the data that will be collected, and the process through which consumers can weigh in during the evaluation process.** These criteria may include plan comprehensiveness, affordability, administrative simplicity, mandate inclusion, and continuity of coverage. In the past, the timeframe for consumers to weigh in on their states' EHB is too short. A structured EHB evaluation process would protect the interests of all consumers and support states in meeting the needs of consumers.

As a part of a structured evaluation process, CMS should use existing networks of consumer advocacy groups as partners in ongoing evaluation. As people enroll in EHB plans, state consumer assistance programs have become well-versed in how well EHBs meet the needs of consumers. Navigators play similarly important roles in identifying gaps in coverage for Exchange populations, as well as where EHBs are working well. By working with consumer assistance groups together with nonprofits that serve vulnerable populations, CMS will gain a more expansive understanding of state EHBs. In addition, CMS should request state departments of insurance (DOIs) for complaint data as it relates to covered benefits in order to gain a more

complete evaluation of EHBs. Consumer health advocacy groups are well-equipped and eager to play this role and develop relationships with CMS. These are the groups that will be most knowledgeable of consumer experience.

The state benchmark approach to EHB, however, continues to raise concerns for consumers. There are several issues for consumers that we would still like to see addressed including incomplete benefit design for pediatric, vision, SUD and mental health services; variability in plans across states; discrimination in plan design; and lack of transparency for consumers in understanding plan attributes. CMS should assess state variability in EHBs; this variation in coverage across states has created inequitable access for consumers, particularly our most vulnerable consumers—children and people with chronic conditions.

§ 156.115 – Provision of EHB

We are pleased that CMS has taken steps to further clarify EHB requirements. Specifically, we applaud CMS for recognizing the need for a uniform definition of habilitative services and the efforts to establish one. We support the definition from the Glossary. **However, we recommend that the definition of habilitative care be amended to include examples relevant to adults, especially those with serious mental illness and/or chronic substance use disorders.** Habilitative services can help adults meet their treatment goals and may include basic life skills, supportive employment, education, and social supports, all with the goal of helping someone live on their own or in a community-based setting. **We also recommend that this definition apply to all states, not just those that currently lack habilitative services or their own definition. This will be especially important in states that have a definition that is less protective than the one established in federal rules.**

Limitations for habilitative services should be established separately from rehabilitative services. Though these services are interdependent and might be used at the same time, we caution against applying rehabilitation limitations (e.g., number of visits, duration of treatment) to habilitation services. Rehabilitative services may not be needed long-term, but habilitation services (especially due to disability) may be required long-term. Limitations should be based on the best available evidence and decisions should be made by professionals with sufficient expertise.

We appreciate CMS providing clarification that children will remain covered through the end of the plan year in which an enrollee turns 19. **We recommend, however, that the age limit for "pediatric services" be raised to age 21.** This higher age limit aligns with existing standards under Medicaid and the Children's Health Insurance Plan (CHIP). This alignment would help ensure continuity of care for children transitioning between coverage options and would allow children with life-long and chronic conditions to continue care beyond age 19 with pediatric providers who have the expertise surrounding their conditions and treatment that adult providers oftentimes do not.

However, pediatric services continue to be negatively impacted by a lack a category definition. The EHB benchmarks are based on the small group market and adult health care needs. Children's health needs are different and the EHB pediatric categories often require

supplementation. **We request that CMS further define the pediatric categories to ensure adequate coverage of services for children, including of comprehensive vision, hearing and dental services in addition to robust preventive services.** This definition could include services from the state's CHIP plan in 2014 or the American Academy of Pediatrics' Scope of Benefits for Children, for example. **To meet this full definition, we recommend that CMS obligate states to supplement their benchmark selection for 2017 with pediatric services across all categories. In addition, CMS should establish stronger transparency standards for states in their review and certification of EHBs to ensure that all benefits are included in full in selections.**

In the preamble of the final rule for EHB, the Department stated that it was "currently reviewing all options for updating EHB in 2016 and anticipate releasing additional guidance in the future on enforcement of EHB requirements and updating EHB." Based on these requirements, **we expect that the Department will still be completing a full review of EHB and its benefit categories, not just habilitative care and the prescription drug benefit.**

§ 156.120 – Collection of Data to Define Essential Health Benefits

We applaud the efforts of CMS to increase transparency through data collection, as data is necessary to support an open dialogue and participation by all stakeholders and will make it possible to conduct analyses regarding state variability and plan benefits. **We recommend that CMS use the collected benchmark plan data to assess EHBs across the states and identify areas of variability. This data can enable departments of insurers to better gauge whether or not EHBs are providing promised benefits to consumers.**

We recommend that CMS not only collect and analyze this data but also make it available to consumers and consumer advocates. To help consumers understand their state's EHB benchmark in an open and transparent process, CMS should provide this information to the public in an accessible and understandable way. Benefit details provide consumers meaningful information about potential EHB plans so that they can choose plans that meet their families' needs. CMS could help by providing data that bring greater transparency in discerning benefits in the EHB benchmark, including the associated detailed plan documents.

We recommend that data collection and reporting by states to CMS and by federal agencies to the public include detailed information about substance use and mental health coverage. In a recent survey of health advocates nationwide by the Coalition for Whole Health, more than half reported having insufficient information to evaluate the mental health and substance use disorders services covered by their state's health plans. This data should be differentiated according to inpatient, residential and outpatient treatment, integrated substance use and mental health treatment, and any limitations on this treatment or treatment coverage.

§ 156.125 – Prohibition of Discrimination

We are pleased that CMS has elevated the issue of discriminatory benefit design, and we applaud CMS for further clarifying how the state and federal government can assess the ACA's non-discrimination provisions by documenting concrete examples of discrimination in health plans,

especially discrimination through age restrictions. **We urge CMS to also include discriminatory benefit design based on "substance use disorders and mental illness" to this list.** In addition, exclusions for otherwise-covered benefits when provided for the purpose of treating Gender Identity Disorder, gender dysphoria, or related conditions contradict the consensus of leading professional medical associations regarding the medical necessity of these treatments for many patients, and they unacceptably limit access to otherwise covered benefits on the basis of health condition and gender identity. CMS has taken an important step in elevating these issues. **We recommend that CMS include this important clarification of discrimination in the regulatory language in addition to the preamble.**

We are concerned, however, that monitoring and enforcement responsibilities are largely devolved to the states. **The final rule should better define how the state and the federal government will monitor and enforce the law's non-discrimination provisions.** CMS should provide sub-regulatory guidance on how to evaluate products for discrimination. In addition, CMS should require trained evaluators to review insurance contracts for discriminatory benefits. We also recommend that CMS consider enforcement options, which could include penalties for plans that are found to be discriminatory by benefit design. In addition, CMS should clearly identify how consumers can submit complaints and to what entity (DOIs, Office of Civil Rights (OCR)) and confirm private right of action. This information should be incorporated into the rule itself and not just in the preamble. Overall, we do not feel it is sufficient to allow all monitoring and enforcement of discrimination to states.

§ 156.220 – Transparency in Coverage

We applaud CMS for requiring QHP issuers to collect and report claims data, and **we recommend that additional data be collected to evaluate compliance with the Mental Health Parity and Addiction Act**.

Despite the law, state advocates across the nation are regularly fielding complaints about parity violations that block consumers' access to needed care. Coverage for mental health and substance use disorders is often not provided at parity with physical health coverage. For example, plans may limit the quantity or frequency of outpatient treatment for behavioral health, but not for outpatient medical visits. Or a plan may impose more restrictive prior authorization policies for behavioral health than for other medical services.

To help identify these parity violations, QHP issuers should be required to submit detailed data that compares plan coverage for mental health and substance use disorders services and medications with coverage for other illnesses, including:

- Quantitative and non-quantitative treatment limitations
- Financial requirements for inpatient, outpatient, emergency care
- Prescription drugs

We recommend that CMS collect data elements that support the evaluation of network adequacy such as number of claims denied for out-of-network care, enrollees spending on out-of-network care, number of claims denied including type of claim, reason for denial (medical necessity, non-covered benefit, etc.), whether a denial was appealed, and

disposition of appeal, for example. This data should be publicly available. Consumer access to this type of data informs their plan choice, holds plan accountable, and is an important barometer of health care access.

§ 156.230 – Network Adequacy Standards

We strongly support CMS's clarification that out-of-network providers cannot be counted in determining network adequacy. This clarification will help prevent confusion consumers might face when accessing care, and will help ensure that consumers have confidence that there are sufficient providers to deliver the benefits promised to them under the plan of their choice.

We also applaud CMS's proposal to strengthen the provider directory requirements to include the information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations. **We also support CMS's requirements that the provider directories must be updated at least once a month and available online to both enrollees and consumers shopping for coverage without requirements to log on or enter a password or a policy number**. These proposals will help ensure that consumers have an up-to-date, accurate and complete provider directory.

To further strengthen provider directories, we urge CMS to consider the following:

- **Require health plans to confirm the network participation of providers who have not been in communications with their contracted health plans in more than a year.** For instance, in New Jersey, managed care plans are required to follow up with any provider who has not submitted any claims to a plan within a twelve-month period to the provider's intention to continue to participate in the plan's network.

- **Allow consumers to access providers at in-network rates should the provider leave the network during the middle of a plan year or if the provider directory was out of date and inaccurately listed a provider as in-network.** If the consumer signs up for a plan because of a specific provider network, and the provider network changes after the consumer is locked into the plan, the risk should fall on the plan for this change not on the consumer.

- **Any care delivered at an in-network facility (and at an absolute minimum any emergency care) should require all provider cost-sharing at in-network rate.** It should not fall on the consumer to assemble a team of in-network providers to do their surgery if they have opted to go to an in-network hospital.

- To accommodate consumers with limited English proficiency and people with disabilities, **we urge CMS to require that the provider directories include information on the language spoken by each provider, interpreter services or communication and language assistance services that are available at the provider's facilities and information about how enrollees can obtain such services, as well as the physical accessibility of the provider's facilities.**

- **Include behavioral health providers in provider directories in a way that makes it easy to search for providers specializing in the full range of treatments for mental health and substance use disorders, including inpatient, residential, outpatient treatment and recovery services.** Expedient access to treatment is especially important for people with substance use disorders because delays in treatment can be fatal. Too often, overdoses occur in the waiting period between seeking and accessing treatment.

While we understand the importance of the results of the National Association of Insurance Commissioners' (NAIC) revision of the network adequacy model act, we urge CMS to act independently to **create clear quantitative standards for network adequacy to ensure that consumers have access to needed care in a timely manner**, **develop requirements that ensure continuity of care protections for consumers.** Given the NAIC's process, there is a strong possibility that the NAIC will not be done with its process in time for plans to file their 2016 QHPs. Also, even if the NAIC model is completed in time this does not mean that states will take legislative action right away. Therefore, it's extremely important for CMS to take steps independently to ensure consumers have access to adequate networks.

§ 156.235 – Essential Community Providers

A majority of Marketplace enrollees are low-income, racially diverse, and have chronic health care conditions. It is critical that health plans are able to meet their needs by maintaining a sufficient number of Essential Community Providers (ECPs) with experience providing quality care to consumers from diverse backgrounds and low-income families with the greatest health needs. ECP inclusion is especially crucial in states that will use Medicaid funds as premium assistance to purchase coverage in the Marketplace for individuals with income at 100% of the federal poverty level.

We appreciate that CMS expanded the list of ECP categories and types to include: (1) not-for-profit or State-owned providers that would be entities described in section 340B of the PHS Act but do not receive Federal funding under the relevant section of law; (2) not-for-profit or governmental family planning service sites that do not receive a grant under Title X of the PHS Act; and (3) other providers that provide health care to populations residing in low-income zip codes or Health Professional Shortage Areas. However, **we strongly urge CMS to further expand this list to include: (1) dental providers; (2) substance use disorders treatment and recovery services providers, and community mental health providers; and (3) children's hospitals and essential pediatric community providers.**

(1) Dental providers: Approximately 83 million people lack access to dental care in this country. Dental access is a longstanding problem for vulnerable populations; specifically, the Medicaid system has largely failed children by not providing them with adequate access to oral health services. The ACA recognizes the importance of dental care through the inclusion of a pediatric dental benefit. However, the network adequacy requirement is vague. Specifically including dental providers and/or requiring inclusion of co-located entities as an ECP category is an important first step in increasing access for consumers.

(2) **Substance use disorders treatment and recovery services providers:** The ACA's coverage expansion, Essential Health Benefits requirement and the Mental Health Parity and Addiction Equity Act (MHPAEA) will significantly increase the number of people who can receive and afford substance use disorders treatment. The explicit addition of substance use and community mental health providers as an essential provider category will help to ensure sufficient access to critical services and bolster efforts to integrate and streamline substance use treatment and recovery services with other medical care. Many of these providers are nonprofit or government-funded agencies that predominantly serve people with low-incomes and those who are medically underserved.

(3) **Essential pediatric community providers for children:** Children are a unique population. To appropriately address the health care needs of all children, regardless of age, networks must include one or more pediatric hospital providers that are in the geographic area and maintain a full range of primary care and pediatric specialty services. These providers should have the capacity to provide care to all covered benefits at every level of complexity without imposing administrative barriers (i.e. prior authorization processes) and/or high cost sharing.

Finally, **we urge CMS to set a higher threshold at a minimum of 50 percent of ECPs in a plan's service area** as opposed to 30 percent set for QHP certification for 2014-2015. Although the proposed rule does not set the threshold, it may address the threshold level again in the forthcoming issuer letter as it has done in the past. We urge CMS to do so. We also suggest that QHPs must include at least one ECP from each category in the network. In a geographically large rural county, one health center located in a corner of the county may not be accessible for those who reside on the other side of the county. Minimal standards on ECP inclusion will fail to ensure reasonable and timely access to care for low-income and medically underserved individuals and their families. At least two states have regulations regarding to ECP inclusion that go beyond the federal rules. Connecticut requires health plans sold in the marketplace in 2015 must include in their networks 90 percent of the federally qualified health centers in the state and 75 percent of ECPs on the marketplace's non-FQHC essential community provider list.[2] Washington State requires that by 2016 health plans must include at least 75 percent of all school-based health centers in the service area in their networks.[3]

§ 156.420 – Plan Variations

We strongly support the requirement that issuers make available to individuals eligible for cost-sharing reductions a Summary of Benefits and Coverage (SBC) that accurately represents the plan variation based on this financial assistance. Consumers cannot otherwise understand how the cost-sharing requirements of their plan will differ from the standard silver plan. Such information is critical both for plan selection as well as understanding plan benefits and cost-sharing once enrolled. In the absence of this information, some consumers who would be eligible for cost-sharing reductions may choose bronze level coverage with substantially

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[2]Access Health CT: Solicitation to Health Plan Issuers for Participation in the Individual and/or Small Business Health Options Program (SHOP) Marketplace
http://www.ct.gov/hix/lib/hix/QHP_Solicitation_031814_Amended.pdf
[3] Washington State, Office of the Insurance Commissioner: CR-103P http://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/documents/2013-22103P.pdf

lower premiums based on a comparison of standard plan materials. Having an accurate SBC would allow for a true comparison and more complete understanding of plan choices.

§ 156.425 – Changes in Eligibility for Cost-Sharing Reductions

As noted above, **it is imperative issuers be required to provide an SBC reflecting applicable cost-sharing reductions to those newly eligible for cost-sharing reductions (or the standard plan variation, if an individual is no longer eligible for cost sharing reductions),** so the enrollee can understand how his/her cost-sharing obligations change with the new plan variation.

§ 156.1130 – Quality Improvement Strategy

We recommend that CMS reinforce stakeholder engagement to inform the development, use and evaluation of the QIS. We applaud the inclusion of stakeholders in creating the initial QIS principles, as well as during development and implementation. In order to reinforce robust, on-going feedback with stakeholder participation throughout the QIS process, we suggest that CMS directly reach out to stakeholders, particularly state consumer health advocates, patient advocates and case managers in the process of developing and evaluating the QIS. These stakeholders fill a critical role in aligning QIS objectives with consumer health perspectives.

We recommend that QIS adopt common collection and reporting standards that can be easily understood and compared, as a mechanism to foster accountability. We recommend a standardized approach in QIS collection and reporting that would foster transparency. While flexibility allows for innovation, standardization is optimal towards easier comparison and performance benchmarking. Public reporting should also factor in the multiple end-users who will be engaged in evaluating QIS activities: state oversight and Exchanges, health plans, consumers, employers, providers and provider organizations. Concurrently, rigorous evaluation and benchmarking provides confidence in what activities lead to more valuable and higher performing care.

Success in quality improvement for Marketplaces can be achieved by using common standards and expectations across health plans (in 2014, many state-based Marketplaces reported their performance data, but not in a standardized way). We also recommend that CMS use consumer-tested language to ensure measures are collected and reported in a uniform format and be publicly displayed. When considering consumers as an end-user, research has shown that consumers prefer individual physician and hospital performance reports to information aggregated at physician group or hospital-wide levels.

We recommend that QIS consider process-level measures and indicators of improvement as it pursues longer-term investments in population health and reducing disparities. We applaud that the QIS guidelines address health and health care disparities. Yet, it is difficult to address population health improvement and health equity through current methods of quality reporting because year-by-year enrollment in private health plans makes a long-term return on investment difficult. We recommend that CMS factor in possible barriers to meaningful evaluation due to issuers changing, removing, or adding plans to the Exchanges, as well as the likelihood that people enroll in different plans year-to-year.

To factor in the complexities of shifting health plans, we recommend adopting a "roadmap" approach that aligns interim reforms with longer-term population health improvements. These interim reforms may include process measures and indicators when outcomes are not available and in cases where they may be helpful in illuminating issues such as incentive design, disparities in care, or risk segmentation.

Respectfully submitted,

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