Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Re: Draft 2015 Letter to Issuers in the Federally Facilitated Marketplaces

February 11, 2014

Families USA appreciates the opportunity to comment on the Draft 2015 Letter to Issuers in the Federally Facilitated Marketplaces (FFMs). We are a national non-profit, non-partisan organization dedicated to the achievement of high-quality, affordable health coverage and care for all.

The content in the letter will have a significant impact on how consumers fare in the FFMs (including partnership marketplaces) in 2015. Robust standards for network adequacy, access to essential community providers, rate considerations, non-discrimination in benefit design, and other issues included in this letter are necessary to ensure that FFM qualified health plans (QHPs) are able to meet consumers' needs. To that end, we offer the following comments.

If you have any questions about these comments, please contact Claire McAndrew at cmcandrew@familiesusa.org or Lydia Mitts at lmitts@familiesusa.org or at 202-628-3030.

Sincerely,

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Chapter 1: Certification Process and Standards for Qualified Health Plans

Section 1: FFM QHP Application and Certification Process

We strongly support the requirement that issuers in all FFM and partnership states submit a complete QHP application for QHPs that they wish to sell through marketplaces in 2015, including for QHPs that were sold in 2014 as well. Since 2014 was the first year of marketplace operations, there were instances in which QHPs were reviewed very quickly, before all QHP information (such as provider network listings or drug formularies) was available. In addition, QHP terms and features may change from year-to-year, warranting a new review. We therefore believe that regardless of whether a QHP was available in 2014, it should be fully reviewed for certification in 2015. We also support that the timeline for stand-alone dental plan QHP application submission will be synchronized with medical QHP submissions.

The QHP certification timeline for both full FFM states and states that are performing plan management functions in a partnership marketplace or on behalf of the FFM indicates that plans will be certified by October 17, 2014, almost one month prior to open enrollment. We urge CMS to make the details of these plans (premiums, benefits, cost-sharing, SBCs, provider directories, formularies, etc.) available to the public once they are certified in October so that consumers, assisters, and researchers can have timely information about the options that consumers will have available to them in preparation for open enrollment.

As much information as CMS can provide about certified plans in advance of open enrollment, including premium rates, would be helpful, as many state departments of insurance may release information about premium rates for QHPs much earlier than October, and in some instances this information may be out of context and confusing to consumers.

We understand that all states review QHPs for market-wide requirements such as essential health benefits (EHB) and actuarial value (AV) standards, unless they explicitly declare that they will not. We believe it is critical that these reviews take place sufficiently in advance of when CMS will issue certifications for QHPs and therefore recommend that CMS require confirmation that plans meet these standards before the end of the QHP certification cycle. This will ensure that these requirements are adequately enforced for all QHPs.

Section 2: QHP Certification Process in a State Performing Plan Management Functions in an FFM

We understand that plan management partnership marketplaces, as well as FFM states that operate plan management on behalf of the FFM, are afforded flexibility in how they assess compliance with QHP certification standards. However, we recommend that all states, including not only plan management partnerships and FFM states performing plan management, but also those with state-based marketplaces, be required to enforce QHP standards that are no less stringent than those applied to the FFM. (For example, no marketplace should be permitted to have network adequacy or essential community provider standards that are less robust than those applied in the FFM.) Such an approach would allow CMS to ensure that all states are truly enforcing the federal statutory and regulatory requirements for QHPs.

We also understand that plan management partnership states and FFM states performing plan management establish their own processes for reviewing plans for QHP compliance before

submitting certification recommendations to CMS. However, we urge CMS to ensure that these processes are sufficient to produce thoroughly reviewed QHPs. For example, it is not clear that states performing plan management are required to establish a process analogous to that established for the full FFM under which plans submit initial QHP applications but then receive correction notices as needed and resubmit QHP data. This process is necessary for ensuring QHP compliance and accuracy of QHP information, and we recommend that CMS clarify that all states performing plan management must establish such a process.

We also urge CMS to ensure that states performing plan management build sufficient time into their review processes before the first QHP SERFF data transfer on August 10, 2014 to thoroughly assess QHPs for compliance with standards and for data accuracy. CMS should consider reviewing and requiring CMS approval of plan management state timelines to ensure that they are sufficient. We are also concerned that some parts of the CMS-proposed timeline for QHP certification in states performing plan management are very tight. In particular, the time between when the FFM notifies states of any needed corrections to the QHP data and the date by which issuers must resubmit plan data is very short given the amount of communication that must occur between multiple entities: the FFM must communicate corrections to the state, then the state must communicate the corrections to the issuers, then the issuers and the state must work together to resubmit changes to the FFM. Under the proposed timeline, this is all intended to occur in a little over one week, from August 26, 2014 to September 4, 2014. CMS should consider whether to require the first SERFF transfer to occur earlier in order to extend this time period.

Section 3: Review of Rates

QHP premium rates and increases are a critically important area for proactive and strong regulation, as well as careful consideration during the QHP certification process, to both protect consumers and to help control future costs associated with federally financed premium subsidies. For 2015, in addition to rate consideration during the QHP certification process, CMS should look closely at the rate review processes in place in the FFM states (including in states that are deemed to have Effective Rate Review programs, as advocates in some states with such programs (such as Ohio) still report a lack of transparency and true opportunity for input).

Section i. Rate increases

As we understand the process outlined in the letter, CMS will consider the actuarial justification in the Uniform Review of Rates Template (URRT), the findings and information submitted as part of a state Effective Rate Review Program (which must include a mechanism for receiving public comments), and any additional recommendations by the appropriate state regulator in assessing whether or not to certify a QHP for the FFM based on its premium rate. We support that CMS is taking into consideration these factors in reviewing rates as part of the certification process, as required by statute.

However, we believe to be most effective, CMS should not look at this information just to decide whether to exclude a QHP from the marketplace (although certainly that authority is needed), but should also use it to communicate with issuers about whether a given rate should be modified in order for an issuer to receive QHP certification. This would prevent CMS from having to make a blunt "yes or no" decision about QHP certification based on a plan's rate and could therefore result in fewer QHP exclusions and more consumer choice. In addition, a process in which CMS

negotiates lower rates after reviewing the information described above would provide CMS more room to protect consumers from rates that, while not egregious enough to exclude a QHP, are higher than they should be.

Beyond reviewing state findings and recommendations from states that are deemed to have Effective Rate Review programs when determining whether to certify a QHP for the FFM, we believe that CMS must perform stronger scrutiny of states' rate review programs that have been deemed compliant to ensure that they are adequate and able to provide information that is robust enough to use in QHP certification decisions. If CMS finds that a state's review process is not living up to federal standards, CMS should require the state to modify its processes in timely manner, prior to QHP certification. If states do not comply in a timely manner, CMS should initiate an independent federal review process that includes an opportunity for public comment. We appreciate the challenges and costs for CMS to conduct independent reviews of rates, but believe it is critical that all potentially unreasonable rate increases are properly scrutinized.

For QHP rate increases that are not required to be reviewed by a state or CMS (those that fall under the threshold for a potentially "unreasonable" rate increase), a justification for the rates must still be posted online, in accordance with the statute. However, the issuer letter allows the rate justification to be posted online in one of two locations (the marketplace website or the issuer's website). We recommend that all justifications be accessible in one location, via the marketplace website. Like the letter requires for provider directories and formularies, this justification should be accessible to consumers via one-click on the marketplace website (with justification postings that require further navigation on an issuer's site or a log-in prohibited). This will make it easier for consumers to find the rate increase justifications. Currently, information about rates on healthcare.gov, even for those rates that are potentially unreasonable, are posted in very complicated formats that are inaccessible to consumers. Therefore, we urge CMS to require clear links to and understandable summary information about each rate justification that is considered in the QHP certification process or otherwise received from an issuer.

We strongly urge CMS to take into account others factors such as rate growth inside and outside the marketplace in 2016 when assessing whether to certify a QHP, as required by statute. We understand that trends in rate increases will be hard to assess in 2015 but the accumulative effect of higher increases over time should be part of the rate review of increases in 2016 and beyond. In 2015, CMS could consider the historical pattern of rate increases for similar plans offered by the same issuer in the state. In addition, we are concerned that for 2014, rates were often approved before provider networks were submitted or even fully formed for a given plan, meaning that premiums didn't take into consideration what level of access enrollees would have to various providers— a factor that should be intrinsically related to the premium rate. We therefore urge CMS to consider whether rates are justified specifically given a plan's provider network when considering whether or not to certify a given plan for the FFM.

<u>Section ii. Review of QHP rates</u>

In this section, CMS proposes to "…conduct an outlier analysis on QHP rates to identify rates that are relatively high or low compared to other QHP rates in the same rating area." We applaud the overall concept of an outlier analysis for each rating area. However, the draft letter to issuers does not provide any detail about how outliers are defined. For example, is this based on an

aggregated measure of rates for an issuer across all plans or for individual QHPs? Will CMS look at outliers in each metal tier? Will CMS only look at the very highest and lowest rates or will CMS use a threshold that reviews any QHP with a rate a certain percentage above or below the median or mean rate? We encourage you to provide more detail and allow consumer advocates to work with you to determine how outliers are defined.

When an outlier is identified, the letter suggests that CMS will consider the state's assessment of the plan's rates when determining if the plan should be certified. We recommend that the identification of an outlier rate trigger not just a state assessment, but also an independent federal review of the rate filing and a process for consumer input into that review process, which includes public posting of the outlier analysis. This independent federal review should include the authority to request additional information or clarifications from an issuer rather than relying solely on the URRT and the package of information provided by the state's review process (for states with processes that are deemed effective) and should also allow CMS to communicate to issuers alternative premium rates that would be deemed acceptable for QHP certification.

Section 4: OPM Certification of Multi-State Plans

We support the Office of Personnel Management's (OPM's) solicitation of additional issuers for offering multi-state plans (MSPs) in 2015. We urge selection of MSPs based on whether the plans can serve areas that currently have little competition among QHPs, as well as whether the plans can offer coverage statewide.

Given the barrier that cost-sharing, such as deductibles, can create for consumers in accessing care, we urge OPM to encourage issuers to propose MSPs with $0 or low deductibles, particularly at the silver level, since this level of coverage is pegged to premium tax credits. We have identified such plans in various FFMs across the country, as well as standardized plans in state-based exchanges that cover numerous services before applying a deductible, and urge OPM to look at such plan designs as models for implementing consumer-friendly cost-sharing requirements when contracting with MSPs. Additionally, to prevent prohibitively high premiums for both subsidized and unsubsidized consumers, we urge OPM to require MSPs to apply no or very minimal tobacco rating.

We also urge OPM to scrutinize the provider networks of proposed MSPs closely, along with the access they provide to out-of-state providers (both in nearby regions/ state border areas and broadly for when individuals travel), before completing MSP contracts. OPM should evaluate MSP proposed networks with geo-access maps as is done in other federal health care programs to identify shortfalls and request that issuers address any shortfalls before completing a contract. This gap analysis should include an assessment of access to essential community providers (ECPs) in the proposed MSP. In addition, OPM must ensure that any plan that receives a MSP contract will comply with all state laws or marketplace standards regarding network adequacy and access to ECPs. Network adequacy, provider directory, and ECP standards for MSPs should be no less stringent than those standards required of other plans in the marketplace, whether it is an FFM or a state-based marketplace.

Chapter 2: Qualified Health Plan and Stand-alone Dental Plan Certification Standards

Section 1: Licensure and Good Standing

We support that, "in addition to requiring state certification of good standing, CMS will consider complaints and other QHP issue oversight findings that occur during the 2014 benefit year in its determination of whether an issuer's offering of a plan is in the interest of consumers." However, it is not clear to consumers or many consumer advocates where QHP complaints should be directed. Information about which state and federal agencies consumers should submit QHP complaints to should be clearly indicated on marketplace websites and on the websites of those agencies. In addition, CMS should clarify and make public information about where within CMS to direct QHP complaints so that they are included in the agency's QHP complaint tracking and can be aggregated and taken into consideration during FFM QHP certification processes.

Section 2: Service Area

We strongly support the robust requirements regarding QHP service areas included in the letter. We believe that for any QHPs requesting a service area that is smaller than a county, a narrative justification should be required to explain why such a service area is necessary and CMS should closely scrutinize the justification.

We strongly support the requirement that QHP issuers may not change their service area after their initial data submission except via petition to CMS and in very limited circumstances. This is essential for preventing noncompetitive modifications to QHP service areas after initial data submissions.

We support that a modification to a service area due to limitations in provider contracting would only be permitted if issuers "provide substantial documentation of their contracting efforts in the geographic areas dropped, including lists of providers with whom the issuer attempted to contract and the contracts offered." When such documentation is provided, we urge CMS to consider requiring issuers to offer additional contracts to providers in the geographic area in question or to modify the terms of the contracts offered, but rejected, to be more acceptable to providers before approving a service area modification. We also support permitting a modification of service area in instances when a state or CMS requests a modification to address an unmet consumer need.

Finally, we support CMS' requirement that if an issuer requests a modification to a service area due to a data error in the issuer's Service Area Template submission, the issuer must provide "significant evidence documenting the error, including evidence in other parts of the QHP Application indicating an intent to cover a different area and/or a mismatch with the service area in the issuer's form filing." This will prevent noncompetitive gaming of service areas after initial QHP data submissions.

Section 3: Network Adequacy

We strongly support a more intensive review of proposed QHPs' provider networks, as proposed in the letter. We support that CMS will no longer rely solely on accreditation status, state reviews, or issuer access plans to assess QHP network adequacy, but will instead require issuers to directly submit provider lists to CMS for evaluation of whether the provider networks meet a "reasonable access" standard. We also support that this assessment will include a special focus on hospital systems, mental health providers, oncology providers, and primary care providers, and we urge CMS to evaluate these categories not just generally but also for whether there is reasonable access to providers in each of these categories who specialize in serving children. In addition, we recommend that CMS add to this list anesthesiologists and hospitalists within in-

network hospital systems, as patients are commonly in situations where these types of providers are out-of-network even if they are treating patients at an in-network hospital.

In reviewing proposed provider lists for reasonable access and whether the networks can provide access to care without unreasonable delay, we urge CMS to use geo-access mapping like is used in other federal health care programs to identify shortfalls. CMS review of network adequacy should include not just access to providers in the proposed QHP's direct service area, but also access to providers in nearby service areas that are commonly relied upon by residents of the insurer's service area. For example, many individuals who live close to state borders may rely on a hospital or specialist that is located within a reasonable distance, but in a different state, and that hospital or specialist may be the only one in the area that can meet their needs. Therefore, networks that do not include such providers may result in inadequate access to care and should not be approved.

When CMS determines that an issuer's network is inadequate under the reasonable access review standard, we urge CMS to instruct the issuer to offer contracts to additional providers (including providers located outside of the QHP's service area, but still within a reasonable distance for enrollees) or to modify the terms of the contracts the issuer has already offered to be more acceptable to needed providers. CMS should review the contracts offered by issuers that are found to have inadequate networks to assess whether they are reasonable. If even with reasonable contract terms an issuer cannot secure a sufficient number of providers in given categories, the issuer should be required to allow enrollees to receive services out-of-network at in-network cost-sharing rates without prior authorization and the issuer should bear the cost of any balance billing by the provider.

We strongly support the implementation of time and distance standards for network adequacy in the FFM. In addition, CMS may want to consider implementing provider-to-patient ratios for specific categories of providers (including primary care providers, mental health providers, and other specialists), appointment wait-time standards (for how long people have to wait to get an appointment with a given provider), and standards to ensure that providers are physically accessible to people with disabilities and to people who are relying on public transportation. CMS should require that issuers that cannot meet such standards allow enrollees to see out-of-network providers at in-network rates without prior authorization and that the issuers bear the cost of any balance billing by the provider. CMS should consider existing state network adequacy standards as models for the FFM (see pages 4-6 of the Families USA issue brief, "Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States," for state models: http://familiesusa2.org/assets/pdfs/health-reform/Consumer-Friendly-Standards-in-Exchange-Plans.pdf.)

We also strongly support CMS implementing a searchable provider directory for FFMs. Consumers should be able to search by a provider's name and see all QHPs in the FFM for which that provider is in network. And, this searchable directory should be accessible to consumers when they are "window shopping," before they create a marketplace account.

Adequately assessing an issuer's network for reasonable access to care and creating a searchable directory are only possible if the network information provided by issuers is accurate. We have been very concerned about inaccurate provider directories that include dead phone numbers and

providers who are not actually in a plan's network. CMS should hold plans accountable for the accuracy of their provider lists, which are required by the Affordable Care Act to be up-to-date and to include information about which providers are not seeing new patients. Providing accurate provider lists should not be a challenge for issuers given that issuers must be aware of which providers are actually in their networks once to pay claims. We recommend that CMS conduct audits or "secret shopper" studies of submitted provider lists to determine if provider contact information is correct and if providers listed are truly in an issuer's network before determining that an issuer's proposed QHP network is adequate.

Section 4: Essential Community Providers

We strongly support the increase in the required ECP in-network threshold for QHPs in the FFM from the 2014 standard of 20 percent of available ECPs in a plan's service area required to be in network to a 30 percent threshold for 2015. However, given that the letter indicates that only one QHP issuer faced a barrier to achieving the 2014 standard, we urge CMS to consider setting the 2015 threshold at 40 percent of ECPs in a plan's service area instead of 30 percent.

Regarding rulemaking, we urge CMS to codify an ECP threshold that increases each year such that by 2017, QHP issuers in the FFM must have at least 75 percent of ECPs in their service area in their network, and 90 percent of federally qualified health centers (FQHCs). This is the standard implemented by Connecticut's health insurance marketplace (Health Access CT), and issuers there are making impressive progress towards meeting this standard.[1] At a minimum, if rules codify the proposed 30 percent 2015 standard, it must be clear that this standard applies only to the 2015 plan year and that the threshold will increase in future years.

We also support the requirement that, in addition to the quantitative ECP threshold, issuers must offer contracts in good faith to at least one ECP in each ECP category in each county in the service area where an ECP in that category is available, to and all available Indian health providers in the service area. However, we urge CMS to modify this standard so that it includes not just counties in the ECP's service area, but also in counties adjacent to the service area, including those that are across state lines. As described above, many consumers rely on providers that cross county lines or even state lines for their care, and there may not be a substitute for these providers in the counties that are in a given QHP's service area. Therefore, QHPs should have an obligation to contract with ECPs outside of (but within a reasonable distance from) their service areas, particularly when they cannot meet ECP standards by contracting with ECPs in their own service areas.

We support that to be considered a good faith offer, a contract must offer terms that a "willing, similarly situated non-ECP provider would accept or has accepted." However, we recommend that this standard state that issuers must not just *offer* a contract in good faith to the ECPs listed above, but actually *complete* a contract with at least one ECP in each category in each county in

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1 See: p. 8 of Claire McAndrew, *Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States* (Washington, D.C., *Families USA,* January 2014) available online at: http://familiesusa2.org/assets/pdfs/health-reform/Consumer-Friendly-Standards-in-Exchange-Plans.pdf and Arlene Murphy, Health Access CT Consumer Advisory Committee, *Health Equity Beyond the Insurance Card: Why Essential Community Provider Requirements Matter* (Presentation at Families USA Health Action Conference, January 2014) available online at: http://familiesusa2.org/conference/health-action-2014/workshops/friday/FamiliesUSAECPSlidesArleneMurphy1.17.pptx.

the service area (and in adjoining counties, including across state lines), where available. These contracts should be offered and completed not prior to the benefit year, as proposed in the letter, but prior to QHP certification so that CMS can ensure that ECP standards are met.

We believe **narrative justifications** should be required of issuers seeking QHP certification not only when they fail to meet the quantitative ECP contracting threshold, but also when they fail to contract with at least one ECP per category per county (including counties adjacent to the issuer's service area). In addition to the content listed as required for and considered by CMS as part of the narrative justification, we believe that CMS should:

- Require the issuer to submit with its justification contracts (including comprehensive information on proposed reimbursement rates) offered to but rejected by ECPs in its service area and in adjoining counties so that CMS can assess whether the contracting terms were reasonable (much like is required on page 18 of the letter for when an issuer requests a modification to a service area based on limitations in provider contracting).
- Require with the submission of the "number of additional contracts the issuer expects to offer for the 2015 benefit year and the timeframe of those planned negotiations" the number and name of ECPs that rejected contract offers but to which the issuer plans to offer a modified contract with terms more acceptable to the ECP.
- Require the names not just of ECP hospitals and FQHCs to which the issuer has offered contracts, but an agreement has not yet been reached, but the names of all ECPs that fall into this category to assess whether the plan would provide adequate access to all categories of ECPs once contracting is complete.

In addition, for the proposed **contingency plan** for an absence of sufficient ECP providers in network, CMS should require issuers to allow enrollees to see out-of-network ECPs at in-network rates, and should bear the costs of any balance billing for the enrollee. Otherwise, issuers may be violating not only the ECP provisions of the Affordable Care Act, but also the nondiscrimination in benefit design requirements. For example, if a QHP does not have any Hemophilia Treatment Centers (HTCs) in network, the plan design would likely discourage the enrollment of individuals with the significant health needs associated with hemophilia, which should be considered to violate the discriminatory benefit design provisions under 45 C.F.R. 156.225.

Regarding the **calculation of whether a QHP issuer meets the quantitative ECP threshold,** we support that individual practitioners having the same address as another ECP on the CMS list will not be counted as a separate ECP. We also support that any write-in ECPs (those not included on the CMS non-exhaustive list) will count toward the denominator of available ECPs for the issuer and that only one write-in per street address will be credited towards the quantitative threshold. Finally, we believe that CMS conducting "targeted audits of issuers that satisfy the ECP standard by virtue of writing in a significant number of their ECPs," as described on page 25 of the letter, is an important oversight function to ensure consumer access to ECPs in all QHPs.

Regarding CMS' **list of ECP Categories and Types** (Table 2.1) we believe that for 2015, the category "Other ECP Providers" should be disaggregated so that STD clinics, TB clinics, HTCs, and Black Lung Clinics are each counted individually, analogous to the way that Ryan White Providers and Family Planning Providers are currently counted in the list. The last category

should then remain a catchall category for "other entities that serve predominantly low-income, medically underserved individuals." At a minimum, HTCs should be listed as an independent category, as their inclusion in networks is necessary for enrollees with hemophilia to receive adequate care.

Regarding **issuers that qualify for the alternate ECP standard,** for those issuers that must submit a narrative justification for how their provider network complies with the regulatory standard, we recommend that this justification include, in addition to the content already listed, an explanation of what public or facility-provided transportation is available for underserved populations to access the in-network provider sites that have services to meet their specific needs. We also recommend that individuals with hemophilia be added to the list of populations that must be specifically addressed in the justification.

In assessing whether an issuer can meet the alternate ECP standard, CMS should consider whether the issuer attempted to contract with medical groups and hospital facilities in counties outside of, but adjacent to, the issuer's service area. If an issuer subject to the alternate ECP standard cannot meet the standard, the issuer should be required to allow consumers to see out-of-network providers at in-network cost-sharing rates and the issuer should bear the cost of any balance billing.

ii. Requirements for Payment of Federally Qualified Health Centers

We support CMS' intention to assess data regarding the degree to which underserved populations are cared for effectively in reference to QHP provider networks and their inclusion of FQHCs and other ECPs. We urge CMS to consider surveying FQHCs and other ECPs regarding their experience contracting or attempting to contract with QHP issuers. Such a survey should assess whether FQHCs and ECPs were approached by QHPs or whether they initiated conversations about contracting with QHPs, how the negotiating process went, and how reimbursement is working for them.

Chapter 3: Qualified Health Plan and Stand-Alone Dental Plan Design

Section 1: Discriminatory Benefit Design: 2015 Approach

i. EHB Discriminatory Benefit Design

The letter to issuers indicates that CMS will largely rely on state reviews of essential health benefits (EHB) for discriminatory benefit design when certifying QHPs for the FFM. It is critical that individual and small group plans offered in FFEs fully comply with the EHB requirements prohibiting benefit designs that discriminate against individuals on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation. As we have expressed in previous comments on the NPRM Standards Related to Essential Health Benefits, Actuarial Value and Accreditation, we have significant concerns that there currently is not a clear standard for assessing whether or not a state is adequately reviewing plans' compliance with nondiscrimination requirements for EHB. We believe it is critical that CMS issue guidance that establishes clear standards for the breadth of plan elements that states must review as part of assessing compliance with these requirements. This guidance should specify that states need to have robust methods for reviewing the following plan elements for discriminatory practices: covered benefits and drug formularies; medical necessity definitions; exclusions; provider

networks; benefit substitution; waiting periods; service areas; rating; visit limits; and utilization management.

This guidance should also outline best practices from states and recommended methods for reviewing these plan elements for discriminatory design. It should also include concrete examples of discriminatory benefit design for each of the above plan elements and across the many protected classes of consumers. This guidance should be publicly available.

We strongly recommend that CMS require states to submit to CMS and make publicly available a written plan that outlines the review process and analytic tools the state will use to review and monitor plans' compliance with EHB nondiscrimination requirements.

It is also vital that there is a clear and transparent process in place for consumers to directly file complaints to CMS about discriminatory practices and benefit design they observe or experience in plans. CMS should continually monitor states' enforcement of these standards and act as back-up enforcement agency in the event a state does not adequately enforce these requirements.

ii. QHP Discriminatory Benefit Design

We support CMS' proposed methods for reviewing QHPs for discriminatory benefit designs and strongly support CMS's proposal to add a review of medical management techniques such as prior authorization and step-therapy requirements for prescription drugs to its review process in 2015. We believe outlier analyses and reviews of plan language can be effective tools to help assess plans. As states and CMS identify other best practices for reviewing discriminatory plan design, we recommend that CMS revise its review process to reflect these best practices. We offer the following recommendations regarding CMS's proposed strategies:

- We recommend that CMS does not limit its outlier analysis of prior authorization requirements to prescription drug coverage, but that it also conduct outlier reviews of prior authorization requirements for medical treatments, particularly in specialty care settings.
- We recommend that CMS clarify that it will review plans that have prior authorization or step-therapy requirements for a significant proportion of the total number of drugs it covers under a particular category and class of drugs. In some categories and classes plans are only required to cover a small number of drugs. It is important that CMS's review ensures that, within these categories and classes, medical management is not used to effectively restrict coverage to only one or two drugs.
- We strongly support CMS's proposal to review plan language, including "explanations" and "exclusions." It is critical to assess whether plans discriminatorily apply higher cost-sharing for services used by specific sub-populations. For example, we have seen plan SBC language that specifies that the general copayment for an out-patient surgical facility fee increases by $1000 specifically for bariatric surgery. We strongly recommend that policies such as this that increase cost-sharing for a treatment or surgery that is uniquely used by a subset of the population (compared to cost-sharing for similar services used by the general population) be treated as discriminatory.

To aid in monitoring and enforcement of nondiscrimination requirements, we strongly

recommend that CMS make the results of these reviews publicly available, including descriptions of the discriminatory benefit design elements identified, so that other issuers can avoid implementing similar policies. We recommend that CMS use these results to periodically issue additional guidance outlining examples of common discriminatory benefit design practices that it has found over the course of these reviews.

In addition to the factors listed for consideration in CMS' QHP discriminatory benefit design analyses, we believe that QHP provider networks should be analyzed for discriminatory practices. In addition to assessing compliance with network adequacy standards, CMS should conduct assessments to ensure that networks are not designed in ways that "have the effect of discouraging the enrollment of individuals with significant health needs" as part of the discriminatory benefit design analyses.

Factors that could indicate a discriminatory network design include a lack of in-network specialists that are essential for delivering services to people with particular conditions (for example, hemophilia treatment centers, Ryan White HIV/AIDS providers, mental health specialists, autism specialists, oncologists, etc.), an insufficient provider- to- patient ratio for given specialists that are essential for caring for certain conditions (including those listed above), or discriminatory tiering such that certain specialists are only available at higher-priced tiers and not at the lowest-cost tiers.

Section 2: Prescription Drugs

We appreciate CMS's attention to ensuring that QHPs include adequate coverage for drugs, including those covered under a medical benefit, as well as self-administered drugs covered under the prescription drug benefit. It is important that consumers have clear and transparent information about what drugs are covered under the medical benefit and the corresponding cost-sharing for those drugs. This type of information is crucial for many consumers with chronic illnesses when selecting a health plan. We strongly recommend that QHPs be required to include information about drugs covered under the medical benefit in their formularies.

CMS must ensure that policies regarding QHP reporting on drugs covered under a medical benefit and how those drugs are counted for meeting the prescription drug coverage EHB requirement are designed to ensure that QHPs offer adequate coverage of both medically administered and prescription drugs. At a minimum, QHP coverage of each of these types of drugs should be comparable to the breadth of coverage offered in the state's benchmark plan. However, it is unclear to us, based on this letter and past rulemaking, whether drugs covered under the medical benefit were counted in establishing the floor for prescription drug coverage in a given state, or even considered at all in establishing the EHB for a state. It is critical that drugs covered under the medical benefits in a state's selected benchmark plan are counted when setting the prescription drug floor of coverage for EHB, particularly if plans are allowed to count these drugs towards meeting the EHB prescription drug requirement.

We strongly support CMS' clarification that plans must provide a direct URL link to a QHP's formulary (including plan-specific cost-sharing and tiering information) and that consumers should not be required to further navigate or log-in to an issuer's website, or to search for a specific policy number in order to locate the correct formulary.

It is critical that the webpage clearly distinguish to consumers which formulary applies to a particular QHP. We have seen some issuers label formularies with identifiers or names that do not match the marketing name visible to consumers at the time they are shopping for plans. This can create confusion for consumers and is particularly problematic if there are multiple QHP formularies housed on the same page.

We recommend that carriers be required to have a separate URL and webpage for each distinct formulary the issuer offers and that this page clearly list which QHPs this formulary applies to, using the marketing name for those QHPs used on the marketplace website. This is the most straight-forward way to ensure consumers always view accurate formulary information when shopping for plans. At a minimum, if a carrier houses multiple QHP formularies on the same webpage, we recommend that the carrier be required to label which formulary applies to which QHP using the QHP's exact marketing name as seen on the marketplace website.

We also strongly recommend that CMS work towards building search functionality on healthcare.gov that would allow consumers to search for plans based on whether or not they cover a specific drug, similar to the search function currently available on Medicare.gov.

We strongly agree with CMS's statement that marketplaces have the authority to require issuers to temporarily cover non-formulary drugs and to waive prior-authorization and step therapy requirements for a particular drug through the first 30 days of coverage. It is our understanding that marketplaces already have this authority, but we support CMS clarifying that this is permitted. As such, we recommend that, in so much as any future rulemaking clarifies that marketplaces are permitted to require coverage of non-formulary drugs for 30 days, it also clarify that this rulemaking in no way limits marketplaces from setting more protective standards. For example, a marketplace has the authority to require issuers to cover non-formulary drugs through a longer transition period, such as the first 60 days of coverage.

We have concerns with CMS's proposal to only extend this protection to consumers whose coverage takes effect January 1 of a given year. Individuals who newly enroll in a plan within the open enrollment period such that their coverage takes effect after January 1, and those who enroll outside of open enrollment due to change in life circumstances should be afforded equal protections to minimize any disruptions in their treatment as they switch to a new health plan. We strongly recommend that in FFMs, CMS require QHPs to cover non-formulary drugs and waive prior authorization or step therapy requirements for the first 30 days of a new enrollee's coverage, regardless of the date on which the consumer's coverage took effect.

We appreciate CMS's ongoing efforts to facilitate minimal disruptions in care as consumers transition to new health plans. We believe it is vitally important that FFMs also have policies in place to minimize disruptions in care created by switching to a plan with a different provider network or different policies regarding coverage of certain medical services. Some state-based marketplaces have already enacted policies to address these concerns.

For example, Maryland (starting in 2015) and the District of Columbia require individual and small group issuers to allow new enrollees undergoing specific courses of treatment to continue to receive care from out-of-network providers for 90 days or through delivery and postpartum visits for pregnant women. Starting in 2015, Maryland also will require individual and small

group issuers to accept prior authorizations for care from relinquishing health plans for all covered services for the lesser of the course of the treatment or 60-90 days (or through delivery and postpartum visits for a pregnant women).[1],[2] Delaware's partnership marketplace has also established continuity of care standards for QHPs. For new enrollees, QHPs must cover any medical treatment that is in progress or that has been preauthorized by an enrollee's previous plan for 90 days or until the treating provider releases the patient from care, whichever is less.[3]

We strongly recommend that CMS adopt similar policies for FFMs that require QHPs to cover medical treatment that is in progress or that has been preauthorized by an enrollee's relinquishing health plan or any care in progress from an out-of-network provider for new enrollees for the first 90 days of coverage or through delivery and postpartum visits for pregnant women.

Section 3: Supporting Informed Consumer Choice

As indicated in our comments on the 2015 Payment Notice, we strongly support the implementation of meaningful difference standards for QHPs offered by the same issuer. Specifically, we support the implementation of quantitative standards for meaningful difference, such as a $50 or more difference in both individual and family in-network deductibles or $100 or more different in in-network out-of-pocket maximums. We are pleased to see these quantitative standards included in the letter, as they were not included in the 2015 Payment Notice and we found that problematic. We urge CMS to implement these quantitative standards as meaningful difference requirements.

In addition, as mentioned in our Payment Notice comments, we believe that the list of plan characteristics to be considered in assessing meaningful difference should be modified to eliminate premiums. Premiums should not be included, as they are not a difference in plan design, but rather a function of plan design differences that are already accounted for in other characteristics (such as provider network, formulary, etc.) included on the list.

Section 4: Stand-alone Dental Plans: 2015 Approach

We are glad to see that CMS will be collecting information on stand-alone dental plans' average charged rates for 2014. We recommend that CMS use this information to monitor rating practices of these issuers, including whether the average rate charged in 2014 was significantly greater than what the issuer initially estimated. As dental plans are still allowed to rate based on health status, we believe it is critical that CMS use this data to monitor these rating practices.

It is unclear to us whether the 2014 estimated rates that dental issuers submitted were based on rates that were calculated without regard to any health status rating or whether they accounted for the projected impact of health status rating among the enrollee population. Starting in 2015, we recommend that CMS require stand alone dental plans to submit estimated rates that are based on the issuers' projected average rates once enrollees are rated for health status. We also

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[1] Claire McAndrew, *Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States* (Washington: Families USA, January 2013), available online at http://familiesusa2.org/assets/pdfs/health-reform/Consumer-Friendly-Standards-in-Exchange-Plans.pdf.

[2] Executive Board of the District of Columbia Health Benefit Exchange Authority*, Resolution: To require Qualified Health Plan (QHP) issuers to establish policies that address transition of care for enrollees in the midst of active treatment at the time of transition into a QHP.* Approved May 9, 2013.

[3] Claire McAndrew, *Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States.*

recommend that in future years, CMS take into consideration stand-alone dental issuers' rate increases when determining whether or not to certify them for the FFM, analogous to the way that rates are considered for medical QHP certification.

We believe that it is critical that if a dental issuer is charging higher rates on average than what they initially estimated that this information is transparently communicated to the public. We recommend that both the average charged rates for 2014 and the previously estimated rate for 2014 are made publicly available to consumers, in addition to the estimated rate for 2015. This information should be displayed in a transparent way, with clear and easily understandable language about what each rate represents, why the estimated rate for 2014 may be different from the average rage for 2014, due to issuer rating (including health status rating), and what the estimated rate for 2015 represents.

Section 7: Coverage of Primary Care: 2015 Approach

We strongly support CMS' proposal to require all plans (or at least one plan at each metal level per issuer) to cover three primary care visits prior to meeting any deductible.

We have significant concerns that many bronze and silver level plans currently sold in marketplaces have unaffordable deductibles. A recent analysis conducted by Avalere found that the average deductible for silver plans is $2,567 and $4,343 for bronze plans.[2] These high upfront out-of-pocket costs are particularly concerning given that many premium tax credit eligible consumers are likely to enroll in bronze or silver plans. Unless routine primary care is exempt from these deductibles, we have significant concerns that moderate-income families will still struggle to afford any care. This proposed policy is an important to step to ensuring that consumers enrolled in health plans across all metal levels are able to afford the routine primary care that they need to maintain their health and prevent avoidable and more complex (and expensive) health problems down the line.

We strongly recommend that this policy be required in all marketplaces, not just the FFM.

Chapter 4: Qualified Health Plan Performance and Oversight

Section 2: QHP Issuer Compliance Monitoring Program

We support that issuers will be required to submit a compliance plan and organizational chart as part of the certification and recertification process. In addition, since CMS is ultimately responsible for the compliance of FFM QHPs with federal laws and regulations, we recommend that CMS also require states to submit information about how they are ensuring issuer compliance with market reforms, and in states performing plan management, with QHP requirements. For example, states should be required to submit to CMS the guidelines they use to assess whether plans are compliant with non-discrimination requirements, mental health and substance use disorder parity requirements, and essential health benefits requirements. These guidelines should be transparent so that the public can understand how states are ensuring health plan compliance with statutory and regulatory requirements.

Section 3: QHP Issuer Compliance Reviews

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2 Avalere, *Analysis: Consumer Deductibles Vary Significantly Across Exchange Plans,* (December 11, 2013), available online at http://avalerehealth.net/news/analysis-consumer-deductibles-vary-significantly-across-exchange-plans.

As described in our comments on the "Licensure and Good Standing" requirements for QHPs, if CMS is going to rely on complaints data as part of QHP monitoring and oversight, CMS should make it clear to consumers and consumer advocates where complaints about QHPs should be directed within CMS. In addition, CMS should publish regular (no less than annual) reports that describe QHP complaints received and how they were addressed so that problems captured with QHPs can be explained and disseminated. That way, other QHPs can use the information to avoid such problems in the future and policymakers and administrators can use the information in taking appropriate action to prevent such problems from happening in the future.

As indicated elsewhere in our comments, we urge CMS to include in its QHP compliance reviews an assessment not just of the availability of provider directories, prescription drug formularies, and summaries of benefits and coverage, but of the *accuracy* of the information provided in these documents.

Section 4: FFM Oversight of Agents/Brokers
We understand that QHP issuers have an obligation to ensure that their affiliated agents, brokers, and web brokers are licensed, registered and trained with the FFM, have executed the FFM Privacy/ Security agreement, and, if applicable, signed the General FFM Marketplace Agreement. However, we are concerned with whether QHP issuers will be able to monitor ongoing compliance of agents, brokers, and web brokers, and all of their downstream and delegated entities with all federal laws and regulations. For example, agents, brokers, and web brokers may be in compliance with all requirements when the issuer completes an agreement with them and provides them access to the issuer's tools, but later in the year they may fall out of compliance. We therefore recommend that CMS conduct compliance reviews to ensure that agents, brokers, and web brokers maintain compliance with federal requirements. In particular, we recommend that CMS take steps to ensure that web brokers maintain compliance at all times with requirements under 45 C.F.R 155.220. We also urge CMS to enact additional consumer protections for web brokers, as outlined in: *Consumer Protections for Web Brokers that Participate in the Health Insurance Marketplace* (Washington, DC: *Families USA,* December 2013) available online at: http://familiesusa2.org/assets/pdfs/Web-Brokers-Brief.pdf.

We strongly support the suggestion that agents and brokers not use "Marketplace" or "Exchange" in the name of their businesses or websites, and recommend adding the word "Market" to that list as well. For example, television commercials for "HealthMarkets.com," which advertise the ability of its brokers to help consumers access marketplace subsidies and health plans, may lead consumers to believe that www.healthmarkets.com is affiliated with an official marketplace due to the similar terminology in the company's name.

Section 5: Monitoring of Marketing Activities
We support that CMS may review QHP marketing materials in states where there is no or minimal review of QHP marketing materials for compliance with 45 C.F.R 156.200(e) and 156.225(b). We also support the recommendation that marketing materials contain a standardized nondiscrimination clause as described in the letter.

The letter indicates that if CMS receives a consumer complaint about an issuer's marketing activities or about an agent's, broker's, or web broker's conduct that is generally overseen by the state, CMS will send the complaint to the state, as appropriate, and take action in accordance

with the state's investigation. However, we are concerned with how CMS will ensure that states take appropriate action after receiving such a complaint. We urge CMS to closely monitor states following such complaints to ensure that they conduct thorough investigations in a timely manner and recommend appropriate enforcement actions. If states fail to do so, CMS should directly investigate issuer, agent, broker, or web broker marketing complaints and directly take appropriate enforcement action against the entities, particularly since compliance issues may be regarding federal statutory or regulatory requirements that are ultimately under federal authority.

Chapter 5: Employee Choice and Premium Aggregation Services in FF-SHOPs
As we have commented in the past, including in our comments on the 2015 Benefit and Payment Parameters Rule, we strongly believe that in all SHOPs composite rating based on an employer reference plan should be available, and we are very dismayed at the decision in the payment notice to preclude this contribution structure in the FF-SHOPs. We urge CMS to reconsider this decision and allow the model described as an "Employee Reference Plan/ Uniform Worker Contribution" model in the following Institute for Health Policy Solutions Brief: http://www.healthexchange.ca.gov/Documents/Small%20Employer%20%28SHOP%29%20Exchange%20Issues.pdf to be implemented in all SHOPs in order to protect older workers from disproportionately high premiums that they will not be accustomed to experiencing.

We support the expectation in the letter that employers in the FF-SHOP will receive aggregated monthly bills that include information about each employee's coverage and the employer and employee contributions toward that coverage. We also support the creation of a designated call center that issuers and employers may contact regarding FF-SHOP issues, separate from the existing healthcare.gov call center.

Chapter 6: Consumer Support and Related Issues

Section 1: Provider Directory
We strongly support the requirement that QHP issuers provide direct links to their provider directories such that consumers do not have to log on, enter a policy number, or otherwise navigate the issuer's website before locating the directory. Locating provider directories for specific QHPs has been a very challenging process for many consumers. We also strongly support that the directory is expected to include "location, contact information, specialty and medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients." We support CMS encouraging issuers to include languages spoken, provider credentials, and whether the provider is an Indian health provider and hope that eventually all issuers include this information, either voluntarily or under CMS requirements.

In addition to challenges accessing directories, there have been many concerns about inaccuracies in provider directories. We urge CMS to implement systems to hold issuers accountable for the accuracy of their provider directories, as inaccurate directories both create complications for consumers but also can mask network adequacy problems by listing more providers as in-network than are truly available. We therefore recommend that CMS:

- Conduct audits of QHP provider directories (such as through a "secret shopper" program) to determine if listed providers are truly in network and if their contact information is correct, and direct QHPs to modify their directories based on the findings of the audits.
- Set specific requirements for QHP provider directory updates: For example, QHP issuers

should be required to make a good faith effort to update their provider directories in real time, and at a minimum to conduct a formal update no less than every two weeks.

- Require QHP issuers to implement a direct system for consumers to report provider directory inaccuracies (such as dead phone numbers, providers indicating they aren't actually in-network, etc.) while viewing the provider directory. Under such a system, consumers should be able to contact the issuer via an email address designated only for provider directory inaccuracy notifications (and not a general email address for inquiries, member services, etc.) or should be able to directly enter a report of an inaccuracy into a web-based comment "pop-up" box that only is used for collecting directory inaccuracy reports.
- Implement a centralized, searchable provider directory for the FFM that not only allows consumers to search by a given provider name to see which QHPs have that provider in network, but also allows for centralized reports of directory inaccuracies and centralized directory modifications. For example, if a provider retires and is therefore no longer in any QHP network, that provider should be able to submit that information to the centralized directory, and the provider should be automatically removed from all QHP listings. CMS should require QHP issuers to make a good faith effort to submit updates received directly by the QHP to the centralized directory in real time, but no less frequently than every two weeks.

Section 2: Complaints Tracking and Resolution

We support that CMS intends to track QHP complaints and use aggregated complaints information as a tool for directing oversight activities in FFMs. In addition, we recommend that CMS monitor QHP complaint resolution processes to ensure that issuers are complying with CMS' expectations that they investigate and resolve consumer complaints in a timely and accurate manner. Compliance with these requirements should be considered in CMS' QHP certification process.

Section 4: Meaningful Access

We urge CMS to develop model notices to assist issuers in meeting meaningful access standards by limited-English proficient (LEP) speakers and by individuals with disabilities, as considered in the letter. We also support QHP issuers following Culturally and Linguistically Appropriate Services (CLAS) standards and ensuring meaningful access to the documents listed in the letter. We urge CMS to codify comprehensive meaningful access standards for QHP issuers in future rulemaking.

Section 5: Summary of Benefits and Coverage

Access to a Summary of Benefits and Coverage (SBC) is critical for consumers comparing their health plan options. This year there have been many concerns with the accuracy of information included on SBCs. For example, many SBCs lack clarity on how deductibles do or do not apply to various services and how family deductibles are calculated (aggregated or separately for each individual). In addition, some SBCs have included information that is simply incorrect and does not match the details of the plan filed by the QHP issuer.

In light of these concerns, we strongly recommend that CMS perform oversight and auditing of QHP issuer SBCs that includes random sampling of SBCs to assess their accuracy against detailed plan submissions. In addition, CMS should require issuers to make corrections as soon

as possible in response to any reports or complaints regarding inaccurate SBC information received directly from a consumer, a state, or from CMS. CMS should monitor issuers for compliance with such a requirement. In addition, CMS should implement the same requirements for direct links to more detailed plan descriptions from SBCs that are being implemented for provider directories (i.e. consumers should be able to access detailed plan manuals that provide comprehensive descriptions of all benefits covered and corresponding cost-sharing requirements with one click from the SBC— they should not have to further navigate the issuer's website, log-in, or enter a policy number).

We oppose CMS' decision that QHP issuers are not required to create separate SBCs to reflect different levels of cost-sharing reductions for each plan variation. Failing to create separate SBCs for cost-sharing reduction plans will leave consumers who qualify for those plans without easy access to an accurate description of the benefits and cost-sharing for which they are eligible. Consumers eligible for cost-sharing reductions may see the "base plan" SBCs and feel dismayed by their cost-sharing requirements, and as a result be discouraged from enrolling. All consumers should have access to SBCs that are accurate for the coverage in which they will enroll, and therefore QHPs should be required to populate SBCs for all plan variations. We do not anticipate that the creation of such SBCs would be burdensome for QHP issuers, as many of the plan details for cost-sharing reduction plans would be the same as for the base plans.