



COMMENTS to the Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services

RE: Draft 2017 Letter to Issuers in the Federally-Facilitated Marketplaces
Submitted by Community Catalyst
January 15, 2016

Community Catalyst respectfully submits the following comments to the Center for Consumer Information and Insurance Oversight (CIIO) and the Centers for Medicare & Medicaid Services (CMS) in response to the Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces, released December 23, 2015.

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.

Overall, we are very pleased that the policies in the letter move toward greater oversight and transparency over health plans offered by insurers through the federally-facilitated Marketplaces (FFMs). We addressed many of these topics in greater depth in our comments to the 2017 Notice of Benefit and Payment Parameter proposed rule and therefore focus our comments here on areas where the letter may be further improved in the interest of the health and wellbeing of consumers purchasing qualified health plans (QHPs).¹

Chapter 2, Section 3. Network Adequacy

i. Network Adequacy Standard

We strongly support the implementation of minimum quantifiable network adequacy thresholds for QHPs in FFEs. These thresholds will do a great service in creating a minimum, commonly understood definition of network adequacy across insurers within a given state, and consumers can have confidence that their plan options must meet a clear, measurable definition of network adequacy.

¹ Community Catalyst's comment letter to the 2017 Notice of Benefit and Payment Parameter proposed rule was submitted on December 21, 2015 and can be accessed here: <http://www.regulations.gov/#!documentDetail;D=CMS-2015-0128-0410>

ii. State Review of Quantitative Network Adequacy Standard

CMS reiterates its proposal to rely on FFE states to review QHPs for network adequacy, provided those states use an “acceptable quantifiable network adequacy metric commonly used in the health insurance industry”. While we commend CMS for recognizing the need for a quantitative standard, we are concerned that relying on a single metric will not be sufficient for measuring network adequacy. Therefore, **we recommend that CMS require states to use a broad set of metrics that take into account geographic variations, regionalization of specialty care services and utilization, and practice patterns.** The National Association of Insurance Commissioners’ (NAIC’s) Model Act includes a list of quantitative criteria that states could use, such as provider-covered person ratios, geographic accessibility (time and distance) standards, and appointment wait time measures.

In terms of provider-covered person ratios, **we recommend that CMS develop criteria to measure provider capacity to ensure meaningful access to health care services for all enrollees.** The metric for determining appropriate numbers of providers should account for the range of services offered by participating providers, and whether providers are accepting new patients. Each year the criteria should be reviewed and updated based on utilization patterns and clinical needs, and to account for provider capacity.

A large number of individuals with limited English proficiency (LEP), as well as individuals with disabilities, purchase health insurance through the Marketplaces. It is critical that QHPs include providers that have the capacity to serve these populations. Specifically, we recommend that CMS require QHPs to:

1. Assess the linguistic capacity of enrollees and provide free language assistance at all points of contact;
2. Conduct regular assessments of provider competency, as well as assessments of physical barriers within provider practice locations and equipment (i.e. the use of appropriate exam tables or diagnostic equipment).

This assessment data should be made publicly available and used to make improvements.

We strongly urge CMS to implement a robust review process with a greater focus on the sufficient inclusion of specific types of providers. **We recommend that CMS look particularly closely at hospital-based physicians at in-network hospitals to ensure that the network includes a sufficient number of specialists, especially emergency doctors, anesthesiologists and radiologists.**

We also urge CMS to implement greater scrutiny on discriminatory practices that create barriers which may prevent particular enrollees from accessing medically necessary care. For example, CMS should review plans for exclusion of providers that serve high-risk populations or specialize in conditions that require costly treatment and utilization controls.

With regard to QHPs that use a tiered network, **we urge CMS to clarify that only providers in the lowest cost-sharing tier will be counted for purposes of determining network adequacy.** Using providers who are assigned to a higher cost-sharing tier can result in significantly more out-of-pocket costs for consumers. Given the significant cost impact, consumers should be able to access all covered benefits through providers in the lowest cost-sharing tier without unreasonable travel or delay.

Finally, we urge CMS to implement Section 2715A of the ACA that requires insurers to report to CMS and state Insurance commissioners on enrollees' cost-sharing and payments with respect to any out-of-network coverage. This data will be a critical tool to assess, on an ongoing basis, whether networks are too narrow in Marketplaces.

iii. Federal Default Standard – Time and Distance

While we generally support using time and distance standards, we reiterate our concern that these standards alone are not sufficient. In addition to the requirement that 90 % of enrollees have at least one provider within xx miles or xx minutes, **we believe that minimum provider criteria is needed to ensure that a sufficient number of providers with the training and expertise are available to actually serve the specific needs of the covered population.** Without specifying and applying minimum provider-to-enrollee standards, consumers, particularly those in densely populated areas, could find themselves within a few miles of a provider but unable to actually get an appointment due to an insufficient quantity of providers. Therefore, we strongly urge CMS to, at a minimum, enumerate and apply minimum provider-to-enrollee standards for QHPs, as is the case for Medicare Advantage (MA) plans.

The provider types being proposed are a subset of the specialty areas reviewed under MA and the time and distance standards are largely the same as those used in Medicare Part C. While using the same standards seems appropriate for many of the specialty areas, such as cardiology and medical oncology, there are some areas where differences in the covered population warrant different standards. Therefore, we make the following recommendations for revising the maximum time and distance standards listed in Table 2.1 in the draft letter:

1. Pediatrics: **We urge CMS to adopt pediatric-specific standards that would allow for an assessment of provider networks that is based on the inclusion of in-network pediatric providers capable of providing appropriate care from well-baby care to care for children and youth with special health care needs, including those with serious, chronic, or complex conditions.** We recommend that CMS set separate primary and specialty care pediatric standards as time and distance to primary care and specialty care pediatric providers can be very different, given the regionalization of pediatric specialty care. In addition, a separate set of network adequacy standards that go beyond time and distance are needed for pediatric specialties and subspecialties, such as pediatric cardiology, neurology, pulmonology, nephrology, oncology, mental health, rheumatology and endocrinology.
2. Hospitals: **CMS should make it clear that only acute inpatient hospitals with emergency departments are counted under this standard.** CMS should consider

measuring inclusion of other types of hospitals, such as children's hospitals, and separate categories should be established for them, as was done for inpatient psychiatric facilities.

3. **Mental health and substance use disorders:** We are thrilled that CMS specifically references providers specializing in mental health and substance use disorders services at the beginning of the network adequacy standard, indicating that QHPs will have to attest to meeting this standard in order to be certified or recertified. However, the quantitative time and distance standards list only mental health as a specialty area. Given the diversity of needs and provider specialties among enrollees in need of substance use disorders treatment, **we urge CMS to have separate standards for substance use disorders treatment. We recommend language that requires at least two in-network providers in every category of substance use disorders treatment² within specified urban, suburban, and rural distances that make sense in the communities served.** These travel time and distance standards should take into consideration geographical and other barriers, such as a lack of accessibility by public transportation, that are not accounted for by simple mileage and travel time criteria. If no network providers meet these accessibility standards, health plans should be responsible for arranging and paying for comparable non-network services at no extra cost to the enrollee.

We note that the MA standards include many more types of specialty physicians and facilities. We are not suggesting that all of the areas used for MA be incorporated into the QHP standards, particularly for 2017. **However, we do believe that the addition of time and distance standards for the following specialty areas is needed:**

1. **Emergency medicine:** We strongly urge CMS to add emergency medicine to the list of specialty providers for which there should be time and distance standards and to align those standards with the hospital standards. This would be a way to help CMS identify where there are not adequate numbers of emergency department (ED) physicians in the health plan's network.
2. **Retail pharmacies:** Access to retail pharmacies is critically important to patients, particularly when they have an acute condition and cannot wait for a medication to be mailed to them. We strongly encourage CMS to adopt retail pharmacy access standards similar to those that exist for Medicare Part D.
3. **Neurology:** Given that neurologists are the physicians that generally care for patients with a wide range of neurological conditions that are likely to be experienced by the QHP population, including concussions, migraines/headaches, epilepsy, multiple sclerosis, and stroke, we support adding neurology to the list of specialty areas for which time and distance standards are established for 2017.

² We define substance use disorders treatment categories as follows: Screening/Assessment, Outpatient Treatment, Intensive Outpatient Treatment, Residential/Inpatient Treatment, Assisted Treatment (MAT), Emergency Services, Recovery Supports, Prevention/Wellness Services.

4. **Outpatient therapy:** We recommend adding at least one but preferably all three of the major therapy disciplines to the list as a way of ensuring that children and adults have adequate access to rehabilitative and habilitative.

iv. Provider Transition

As mentioned in our comments on the proposed Benefit and Payment Parameter rule, we commend CMS for recognizing the need for consumer notification and a transition period when one of their providers is being discontinued from their plan's network. We generally support these proposals, but encourage CMS to carefully consider and implement our previous recommendations for improving upon them as CMS works to finalize both the Benefit and Payment Parameter rules and the Letter to Issuers.

v. Network Transparency

With the growth of narrow networks and lack of out-of-network coverage, it is critically important that consumers understand the network that comes with the plan they are choosing and the trade-offs that come with that choice. We appreciate the additional detail included in this letter about the methodology CMS is considering using for the 2017 plan year. We commend CMS for planning to provide separate ratings for breadth of network by categories of providers as well as a composite rating of overall network breadth. However, **in addition to focusing on hospitals, adult primary care, and pediatric primary care, we encourage CMS to also consider adding separate classifications for the most commonly used specialty physicians for 2017.** In future years, we also recommend that CMS distinguish between hospital types. We recommend that CMS add the following categories of provider classifications:

1. ED physicians who practice at an in-network hospital;
2. Adult physician specialists (non-ED physicians, such as anesthesiologists and pathologists) who practice at an in-network hospital;
3. Adult specialists who practice in office-based settings, such as cardiologists and psychiatrists; and
4. Pediatric specialists.

The categories we propose adding would give consumers a better understanding of their ability to access needed care. Especially, consumers with chronic illnesses will find it very helpful to have an understanding of their plan's network breadth with respect to specialty care. In future years, CMS should consider expanding the categories of specialists so that consumers with particular conditions can obtain rating information on different aspects of their care.

We also recommend that CMS use a broader set of providers as the denominator when calculating the Provider Participation Rate, instead of using only the total number of providers contained in QHP networks. For instance, CMS could instead use the total number of licensed physicians or hospitals for each category type as the denominator or the number of

Medicare providers for that category (although a different data source would likely be needed for the pediatric categories). Such an approach would give consumers a more accurate picture of a network's ability to meet their health care needs.

We believe that the proposed nomenclature – the “basic” and “standard” labels – is not clear and could be confusing to consumers. We instead suggest the use of “narrow,” “average,” and “broad” as terms being more intuitive to consumers. However, as for all consumer-facing tools, we strongly urge CMS to conduct consumer testing to inform which terminology to use and how best to display this information for the public.

vi. Out-of-Network Cost Sharing

We appreciate that CMS acknowledges the problems that out-of-network cost-sharing poses for consumers when they receive covered services by an out-of-network provider at an in-network facility, often without their knowledge or control. Unfortunately, however, we remain very concerned that the remedy being proposed by CMS in the Benefit and Payment Parameter Notice and Issuer Letter does very little to address the financial harm that consumers experience in these situations and is significantly weaker than the provisions included in the NAIC's Model Act. **We strongly urge CMS to adopt the recommendations we made in our comments with respect to the Benefit and Payment Parameter rule when finalizing the rule and this Issuer Letter.**

Chapter 2, Section 4. Essential Community Providers

Many QHP networks during the 2014 and 2015 coverage years left consumers without adequate access to health care providers. We are disappointed that the essential community provider (ECP) standard has not been improved upon from the 2016 Letter to Issuers. We call on CMS to considerably strengthen and clarify the ECP standard in key ways to ensure provider networks are sufficient to meet peoples' needs as they enter the Marketplace.

We urge CMS to consider setting the 2016 threshold at 50% of ECPs in a plan's service area. 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.

We strongly urge CMS to clarify that issuers must include in their QHP networks (not simply offer a contract to) at least one ECP in each category in each county in the service area. The ECP percentage threshold helps enable access to ECPs overall, but it does nothing to ensure patient access to a broad range and distribution of ECP provider types. The ECP categories are distinct in important ways. ECP categories – such as family planning providers, Ryan White providers, Indian Health providers, and ECP hospitals – often provide specific services tailored to meet the needs of certain populations or sub-populations. In addition, we strongly urge CMS to expand the ECP categories to include:

1. Substance use disorders treatment and recovery services providers, and community mental health providers; and

2. Pediatric providers, inclusive of pediatric specialists and subspecialists.

CMS should implement robust monitoring and enforcement of the ECP standards to protect access to ECPs in QHP networks throughout the coverage year. Specifically, CMS should clarify that, after QHP certification and throughout the year:

1. CMS will continue to assess provider networks and monitor QHP contracting to identify patient access and narrow network concerns;
2. CMS may require issuers to offer contracts to additional ECPs at any point during the year to ensure patients have adequate access to health services;
3. CMS will monitor QHP contracting to ensure that issuers do not discriminate against ECPs through contract negotiations and to make sure contracts are offered in good faith; and
4. At a minimum, CMS will make public issuer narrative justifications describing how the issuer's provider network, which fails to meet the ECP minimum threshold, provides enrollees with access to services. We further urge CMS to monitor issuer compliance with the processes and protections outlined in the narrative.

Chapter 2, Section 7. Quality Reporting

We are pleased that CMS clarifies quality reporting requirements of QHP issuers related to the Quality Rating System (QRS) and QHP Enrollee Experience Survey.

We understand that the limited number of child-only QHPs and enrollees may prohibit reliable child-only quality results. Even so, about 726,000 children and youth are enrolled in Marketplace plans on Healthcare.gov – which is still significant and could serve as a dataset for quality and enrollee experience.³ While we appreciate that CMS will continue to monitor child-only QHPs and consider developing a QRS and QHP Enrollee Survey for child-only plans in the future, **we urge CMS to take more formal steps to ensure quality monitoring and data collection now. At the very least, CMS should clarify what this monitoring entails, including the criteria used to evaluate the quality and enrollee experience of these plans, and provide opportunities for stakeholder input.** This is especially important given the uncertain future of the CHIP program past September 2017, entailing a potential influx of children moving from CHIP to the Marketplace. Given that QHP plans are less comprehensive and affordable than CHIP,⁴ it is important to start monitoring the quality and enrollee experience of child-only QHPs *now*. We recommend that CMS in its data collection strategy consult with state consumer advocates and other stakeholders who understand the experiences, needs, and concerns of those with child-only plans.

³ ASPE. (March 10, 2015). Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf

⁴ <https://www.medicaid.gov/chip/downloads/certification-of-comparability-of-pediatric-coverage-offered-by-qualified-health-plans.pdf>

We urge more opportunities to make sure these quality requirements are actually serving and capturing the voice of consumers. Thus, **we recommend that other stakeholders (besides QHP issuers) be able to review QRS and QHP Enrollee Survey results during the established review period each year prior to public display of results.** CMS should consider input received by stakeholders to most accurately review and portray the quality and enrollee experience of QHPs.

Chapter 2, Section 8. Quality Improvement Strategy Requirements

We recommend that consumers be among the stakeholders represented during the annual QHP evaluation process as part of QHP certification. We ask that CMS clarify the process for stakeholder input.

Chapter 2, Section 9. Review of Rates

We support CMS’s continued commitment to review all rate increases with consideration of insurers’ data and justifications for such increases for all plans seeking to participate in the Marketplace. As outlined in the draft letter, when reviewing rate increases CMS will also consider recommendations by applicable State regulators about patterns or practices of excessive or unjustified rate increases and whether or not particular issuers should be excluded from participation in the Marketplace. **We believe that working with state regulators to understand patterns in unjustified rate increases is an important way to hold insurers accountable and to ensure that consumers have affordable QHP choices.**

We also support CMS’s proposal to require that issuers submit a Unified Rate Review Template (Part I of the Rate Filing Justification) for all single risk pool coverage products in the individual, small group or merged markets. We agree that premium increases cannot reasonably be monitored without evaluating the net effect on premiums, including the impact of rate decreases, plans with unchanged rates, and new plans’ rates.

Chapter 2, Section 10. Discriminatory Benefit Design

i. EHB Discriminatory Benefit Design

We are pleased that CMS continues to elevate the important issue of discrimination in Essential Health Benefit (EHB) design. **We encourage CMS to include discriminatory benefit design based on “substance use disorders and mental illness” in addition to the enumerated list of characteristics that may not be used to discriminate in EHB design as stated in 45 CFR 156.125(a).**

While we understand the reasoning for CMS to leave oversight of discrimination in EHB design to states, we are concerned that many states lack the necessary authority, expertise, tools or political will to enforce these non-discrimination provisions. We strongly urge CMS to better define how the state and federal governments will work jointly to monitor and enforce EHB non-discrimination provisions. As such, **we urge CMS to continue to closely monitor state activity**

and to act as a secondary enforcer to ensure that the EHB provisions are not, for example, excluding care for certain chronic conditions.

One piece of information that is critical to review, but not included in CMS's standards for QHP benefit design standards, is an assessment of plan compliance with the Mental Health Parity and Addictions Equity Act (MHPAEA). We recommend that CMS collect and review the following information as part of the QHP application to assess compliance with non-discrimination standards:

1. Documentation of the processes, strategies, evidentiary standards, and other factors used to determine medical necessity and to apply other non-quantitative treatment limitations (NQTL) for mental health and substance use disorders and for medical and surgical benefits;
2. Classifications for mental health and substance use disorders and for medical and surgical benefits.

We also appreciate CMS's clarification that age restrictions for clinically appropriate care are discriminatory. **However, we ask that CMS revise this section to include further clarification for insurers regarding discriminatory plan design and/or the discouragement of enrollment by individuals with chronic mental health or substance use disorders.** These restrictions could include limitations on mental health- or substance use disorders-related care, exclusions of certain levels of care (for example, limits on medically necessary long-term residential treatment), or issuer exclusions of drugs that treat certain mental health or substance use disorders or the placement of these drugs exclusively in higher-cost tiers.

ii. QHP Discriminatory Benefit Design

We applaud CMS for continuing their commitment to review and identify QHPs that are outliers for out-of-pocket costs associated with standard treatment protocols for specific conditions, including several key behavioral health conditions. Additionally, we applaud CMS's decision this year to analyze information contained in the Plans and Benefits Template to identify discriminatory features or wording. We support these review efforts as a necessary step in ensuring that QHPs offer all consumers accessible treatment that follows the standard of care.

However, we urge CMS to make these outlier analyses available to the public and to take action should they find discriminatory actions in their review. As CMS finds instances of discriminatory benefit design, this information should be made publicly available so that everyone, including insurers, can identify prohibited practices on an on-going basis instead of relying on limited examples provided in the issuer letter each year. Additionally, CMS should clarify what consequences will result from a finding of discriminatory benefit design. We urge CMS to consider not allowing QHP certification for plans that are found to violate any of the ACA's non-discrimination protections.

Chapter 3, Section 1. Provider Directory Links and Provider Lookup Tool

We strongly support requiring QHP issuers to maintain and publish up-to-date and accurate provider directories and provide a way for the general public to access these provider directories through links. Specifically, we support the standard for “up-to-date” as monthly and feel this standard will help keep consumers apprised of recent changes or additions to the directories while also promoting administrative efficiency for issuers. Furthermore, we support the standard for “accessible,” particularly the requirement that the general public be able to view the directory without entering an account or policy number. We also support efforts to make clear the plans and provider networks associated with each provider, including the tier in which the provider is included, as this information is important to consumers when choosing a plan.

However, **we recommend that CMS provide further guidance to issuers and stronger enforcements of the requirement to make provider directory information available to prospective enrollees.** During the current open enrollment period, we received reports from assisters that when some consumers called issuers to verify whether their provider was in-network, as the provider-directory tool disclaimer language recommends, the issuer refused to provide the information unless the consumer had a Member ID or account number. Therefore, we think more action needs to be taken to ensure provider directory information is available to the general public in ways addition and that issuers are making this information available to prospective enrollees as well as current enrollees.

We also recommend that CMS enforce a uniform due date for QHP issuers to ensure their provider directories are up-to-date before the beginning of any open enrollment period so that uninsured and renewing consumers can view provider directory information for all available plans. We received reports from assisters and consumers that the window-shopping tool provided inconsistent provider directory information before and during the beginning of the 2016 open enrollment period, in which some plans displayed the information when others did not. Moreover, when some consumers called their providers to ask which issuer they accepted, certain providers did not have the information because they had not finalized their contracts yet. Therefore, we recommend CMS require the provider directory URLs to be up-to-date for any upcoming open enrollment period on a uniform date.

Lastly, **we strongly applaud CMS for creating the provider lookup tool for the 2016 open enrollment period and support its continued operation in future open enrollment periods.** Overall, our assister network has been reporting positive experiences with the tool, such as that it is easy to use and that consumers appreciate being able to search for plans based on their preferred providers. However, as requested above, **we recommend requiring a uniform due date for all QHP issuers before any open enrollment period to ensure their provider directories are up-to-date, so that consumers who use the tool have access to complete and accurate information.**

Chapter 3, Section 2. Formulary Drug List and Formulary Lookup Tool

Similar to the provider directory link mentioned above, we strongly support requiring issuers to maintain and publish an up-to-date and accurate drug formulary list. We support the information that the list will include, as this information is important to many consumers when choosing a plan. We also support the standards for “complete,” but **we recommend CMS require issuers to list every covered formulation for each covered drug.** We believe most consumers would find this information valuable and providing this information will better support consumers to make informed decisions. We do not think consumers should have to take extra steps to find out this information while other information is readily provided.

Similar to the provider lookup tool discussed above, we strongly support CMS for creating the formulary lookup tool for the 2016 open enrollment period and support its continued operation in future open enrollment periods. Our assister network reported positive experiences with the tool and that consumers appreciated searching for plans by their current medications. However, we recommend increasing and improving the information provided by the formulary lookup tool within the window-shopping feature of HealthCare.gov. The onscreen results currently only list whether a drug is “covered” by a plan, and do not provide further information on whether the drug is in a particular tier or whether restrictions apply, such as step therapy, pre-authorization, or refill limits. Assisters request that the tool provide more information on how a drug is covered to better support consumers to make informed decisions.

Similar to the provider directory link mentioned above, we strongly support requiring issuers to maintain and publish an up-to-date and accurate drug formulary list. We support the information that the list will include, as this information is important to many consumers when choosing a plan. We also support the standards for “complete,” but **we recommend CMS require issuers to list every covered formulation for each covered drug.** We believe most consumers would find this information valuable and providing this information will better support consumers to make informed decisions. We do not think consumers should have to take extra steps to find out this information while other information is readily provided.

Chapter 3, Section 3. Out-of-Pocket Cost Comparison Tool

Similar to the provider and drug formulary lookup tools discussed above, **we strongly support CMS for creating the out-of-pocket cost calculator within HealthCare.gov’s window-shopping tool and support its continued operation in future open enrollment periods.** Our assister network reported positive experiences with the tool and that consumers appreciated being able to estimate out-of-pocket costs based on the anticipated utilization levels of household members applying for coverage. However, we recommend CMS take steps to improve the tool’s accuracy for future open enrollment periods. Our assister network reported several technical issues with the tool this year, such as requesting utilization levels for all individuals in the household rather than only the individuals applying for coverage and including individuals who are not applying for coverage in the “People Covered” and “Plan Results” pages.

Chapter 5, Section 2. QHP Issuer Compliance Monitoring.

We support that good faith is no longer a defense to noncompliance starting at the end of 2015. Additionally, as a part of a structured process to determine compliance, **we encourage CMS to use existing groups that work with consumers, including Navigators, Certified Application Counselors (CACs), and consumer advocacy groups as partners in ongoing monitoring.** As individuals have enrolled in QHPs, those providing assistance on the ground have become well-versed in how well plans meet the needs of consumers. By working with consumer assistance groups and nonprofits that serve vulnerable populations, CMS will gain a more expansive understanding of QHPs' compliance.

Chapter 5, Section 3. QHP Issuer Compliance Reviews

We applaud CMS for conducting expedited compliance reviews of issuers when needed to ensure that potential problems can be addressed early on. We appreciate that CMS will publicize the summary of the results of the reviews that CMS conducts with the states and the lessons learned with issuers. **We also urge that in addition to State regulatory entities, CMS coordinate with existing groups that work with consumers, including Navigators, Certified Application Counselors (CACs), and consumer advocacy groups in the compliance review process.**

Chapter 5, Section 4. FFM Oversight of Agents and Brokers

Overall, **we strongly support CMS's policies and procedures for registering, licensing, and monitoring agents and brokers enrolling individuals in the FFEs.** We urge CMS to retain greater oversight over agents and brokers in 2017. For example, while we appreciate the proposed enforcement mechanisms such as termination and suspension, we also recommend providing recourse options for consumers who receive misinformation or an erroneous eligibility determination from an agent or broker and are subject to the individual shared responsibility payment (ISRP) or APTC repayment as a result. Our assister network has reported instances of agents and brokers providing misinformation to consumers and erroneously enrolling them in coverage with and without APTCs. Therefore, we recommend providing remedies for consumers in these situations, such as through exemptions from the ISRP or APTC repayment safe harbor provisions so that they do not experience additional harm as a result of agent or broker misconduct.

We recommend that CMS require all agents and brokers to disclose to the FFE and applicants any relationships the agent, broker or sponsoring agency has with QHPs, as well as any other potential conflicts of interest. We recommend that CMS develops standards for the types of relationships and potential conflicts of interest that must be disclosed, as well as the format for disclosing such relationships or conflicts to applicants (i.e. both verbally and written in plain language). This information is important not only to consumers, but also to CMS in identifying patterns of enrollment that suggest intentional steering to a plan.

We also recommend that the agents and brokers be required to receive training on Medicaid and CHIP, as well as how to provide culturally and linguistically appropriate services, especially to vulnerable low-income families. This training should include how to assist limited-English proficient individuals and immigrant families, especially those with mixed immigration status.

As mentioned in our comments to the proposed Benefit and Payment Parameters rule, we applaud CMS for proposing to streamline the application process for consumers who enroll with the assistance of agents and brokers. We are concerned, however, that the proposal to allow brokers to conduct end-to-end enrollment through an Marketplace-approved web service will negatively impact consumers.

As specified in § 155.220(c)(1), currently, agents or brokers that conduct direct enrollment through a web-broker must direct consumers to the Marketplace website to complete their applications and receive their eligibility determination. Even with this current system, many consumers who enroll with agents or brokers are enrolling in coverage without making an account on the Marketplace website. Many consumers are unaware that they have an application with the Marketplace and that they can create and link an account to that application. This prevents these consumers from reporting life changes on their applications and from returning to the Marketplace for the renewal process online.

Therefore, while the end-to-end streamlining of the application may improve the consumer experience while they are working with an agent or broker, more consumers will not be informed of how to access their applications online. **We recommend that, if agents and brokers are able to conduct end-to-end enrollment through a web-broker, they be required to instruct consumers as to how to create an account on the Marketplace website, how to link that account to their new application, and how to access the application online.**

We also strongly support requiring non-FFM front-end websites to contain explanatory language informing consumers whether they are applying for marketplace coverage so that consumers can have access to complete and accurate information and make informed decisions.

Regarding agent and broker compensation, **we recommend that CMS take additional steps to strongly enforce its rule requiring QHP issuers to provide the same compensation to agents and brokers for QHPs offered through the FFE as they do for similar health plans offered outside the marketplace. We also recommend that CMS require QHP issuers to provide the same compensation to agents and brokers for enrollments in marketplace plans at all metal levels.** We have received reports that issuers in SBE states are not compensating agents and brokers for enrollments in gold or platinum level plans and request that better protections are in place so consumers are not steered towards particular marketplace plans that may not meet their health needs or financial circumstances.

The proposed language on agent and broker compensation also mentions that if an agent or broker is also acting as a Navigator, CAC, or other non-Navigator assistance personnel, that they should follow any state rules regarding charging consumers directly for their services. We feel

consumers may be unaware that agents and brokers can charge consumers directly for services and may be confused as to why an FFM-certified assister is charging for services. Therefore, **we recommend requiring agents and brokers to provide notice to consumers explaining that the compensation is tied to their role as an agent or broker and not as an FFE-certified assister, as well as explaining that the marketplace provides free in-person assistance and how consumers can find this assistance if needed.**

Chapter 7, Section 1. Consumer Case Tracking and Resolution

We applaud CMS for enabling the consumer cases and complaints program to accept member complaints directly. We applaud CMS for taking a proactive role in forwarding complaints to QHP and SADP issuers operating in the FFMs and SBM-FPs. **We would like further clarification on the process for consumers who wish to make complaints and how CMS intends to oversee these processes.** Specifically, we ask that CMS facilitate and clarify how it intends to strengthen consumer knowledge about their complaints options through consumer education, outreach, and equipping consumer assisters. Achieving this would enable CMS and QHP issuers to have a comprehensive and accurate understanding of QHP issues to address.

We recommend that CMS utilize the navigator and consumer assistance call centers to track and compile complaints. We recommend that complaint data be transparent and available, at least in aggregate form, by carrier. This data should be tracked and compiled in a way that distinguishes between behavioral and physical health complaints and allows for a meaningful assessment of parity compliance. This will provide CMS with a more expansive understanding of systemic issues and changes to make in the future.

Chapter 7, Section 3. Meaningful Access

We applaud CMS for releasing guidance in February 2016 identifying the non-English languages that are triggered by these standards for each state as well as sample taglines.

We are also encouraged to see threshold requirements given to taglines and translation of website comments that apply to QHP issuers. **To ensure meaningful access for individuals with limited English proficiency (LEP) we recommend the following strengthened minimum standards:**

1. The translation of forms and notices (including website content) used or produced by QHPs when a language group is five percent of plan enrollees or 500 people. We draw the five percent standard from the Department of Justice (DOJ) and the Department of Health and Human Services' Limited English Proficiency Guidance, and the 500 person standard from the interim final rule established by the DOJ, HHS and the Department of Treasury governing appeals documents in non-Medicare health plans. All forms and notices should be written in plain language and provided in a manner that ensures meaningful access to limited English proficient individuals.

2. Taglines on **non-vital notices** indicating the availability of translated material or oral interpretation in the top 15 non-English languages in the state. This is the current standard used by Medicare and the Social Security Administration.
3. Free access to oral interpreters or bilingual staff on request, regardless of whether thresholds for written translation are met.
4. The translation of the content of QHP issuer websites with materials in English into Spanish and include taglines in the top 15 non-English languages in the state, indicating the availability of free language assistance services through an issuer's call center.

Chapter 7, Section 4. Summary of Benefits and Coverage

It is very important that critical improvements to the SBC be effective for January 1, 2017, in order to ensure that essential information is provided to consumers. We believe a narrow set of improvements could be made to the proposed template that was published alongside the proposed SBC rule in December 2014 and, because such changes would not be considered significant for purposes of the Paperwork Reduction Act, could be implemented without delaying the January 1, 2017 effective date.

The one change that should be made to the template itself (as opposed to the instructions) would be to add a question to the first page of the template: "Are there services covered before you meet your deductible?" The coverage of services before the deductible is a very important feature for consumers, and one on which plans offered through the Marketplace often vary. Under the existing template and instructions, however, this information has not been consistently available, and in many cases it has not been available at all. Marketplace assisters have observed that high deductibles can deter enrollment, and they have observed significant confusion among consumers about how cost-sharing charges work.

Four minor changes in the instructions would increase the value of the SBC for consumers and would better ensure that clear, accurate information about covered benefits and cost-sharing charges is included in the SBC.

1. The "why this matters" column on the first page should inform consumers whether family deductibles and out-of-pocket limits are embedded or non-embedded (aggregate). Consumers shopping for family coverage need to know how the deductible and out-of-pocket limits apply to individuals within the family in cases where an individual has met the individual deductible or out-of-pocket limit but the family has not met the family deductible or out-of-pocket limit. This is an issue that assisters have identified as a key source of confusion for consumers.
2. The instructions should be clearer that where networks contain multiple tiers, the issuer or plan must identify the cost-sharing for each tier independently. The current template only includes columns for in-network and out-of-network providers and the instructions are not entirely clear about the obligation of plans and issuers to add columns for additional tiers.

3. The instructions for the “limitations and exceptions column” for the common medical events pages give significant discretion to issuers and plans and make it more difficult for consumers to compare plans. The NAIC-recommended instructions, submitted to the Tri-Agencies in October, 2015, said the column must indicate three pieces of vital information:
 - a. when a service category or a substantial portion of a service category is excluded from coverage (e.g., column should indicate “brand name drugs excluded” in health benefit plans that only cover generic drugs);
 - b. when cost sharing for covered in-network services does not count toward the out-of-pocket limit;
 - c. limits on the number of visits or on specific dollar amounts payable under the health benefit plan; and when prior authorization is required for services.

CMS should incorporate this vital information into the SBC instructions.

4. The current instructions for the coverage examples provide that cost sharing for the diabetes example should be calculated assuming the enrollee is participating in a wellness program if one is available. Generally in the ACA rules--for example, when determining affordability of employer coverage for premium tax credits or for the individual responsibility affordability exception—the assumption is that consumers are not participating in wellness programs. That should be the assumption for the coverage examples as well.

Thank you for your time and consideration of our comments. If you have any questions regarding our comments, please do not hesitate to contact Ashley Blackburn at ablackburn@communitycatalyst.org.

Respectfully submitted,



Robert Restuccia
Executive Director
Community Catalyst