December 21, 2015

Acting Administrator Andy Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-8016

Re: Comments on *Notice of Benefit and Payment Parameters for 2017 Proposed Rule*, CMS-9937-P

Dear Mr. Slavitt:

The Center for Public Policy Priorities (CPPP) respectfully submits the following comments to the Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) in response to the Notice of Benefit and Payment Parameters for 2017, released on November 21, 2015.
CPPP is a nonpartisan, nonprofit 501(c)(3) policy institute established in 1985 and committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. Improving access to health care for Texans has been at the core of our mission and activities since our founding 30 years ago.

CPPP appreciates the opportunity to provide comments on the proposed Benefit and Payment Parameters for 2017, which strengthen consumer protections in many areas, notably around network adequacy and qualified health plan certification standards. Our comments highlight areas where the rules can be further strengthened, often drawing on our experience in Texas, which has made incremental but consistent progress around balance billing and network adequacy issues over the last decade.

We signed onto additional comments in conjunction with the Texas Association of Community Health Centers that address proposed regulations about Navigators, Certified Application Counselors, income verification, redetermination, annual open enrollment period, and exemptions. These comments separately address other areas of the proposed regulations including network adequacy, QHP certification, essential community providers, and rate review.

<u>Part 154 – Health Insurance Issuer Rate Increases: Disclosure and Review Requirements</u>

§154.215 Submission of Rate Filing Justification

We support CMS's proposal to require that issuers submit a 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.

We believe that §154.215(h)(2) should be strengthened by requiring disclosure/posting of all submitted rate filing information, as opposed to just filings that propose increases. We think that the proposal to post the justifications for all increases is a step in the right direction, but is not sufficient to realize CMS' stated goal of providing the public with comprehensive information and increasing transparency. To do that, filed information on rate decreases and unchanged rates should be

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posted as well. The Texas Department of Insurance does not post any rate information publicly and advocates have been unable to get rate filing information in the past, even when using the state's Open Records process. Federal posting of all rate information filed with HHS, including for rates that decrease, remain flat, or increase less than 10 percent, will greatly increase transparency for Texas consumers.

Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

§ 155.170 Additional Required Benefits

We urge CMS to conduct transparent, continuous, and meaningful oversight of EHB base-benchmark plans and subsequent plan benefit packages that will take effect at the beginning of 2017. We also urge CMS to provide a clear and publicly available timeline of how CMS will enforce and monitor EHB in direct enforcement states such as Texas, where EHB is not overseen by a state regulator. We submitted comments on the EHB base-benchmark plan process that pointed out several specific gaps in the benchmark. Especially for direct enforcement states, CMS must review each QHP submission to determine compliance with all federal requirements, including Section 1557 and the 2008 Mental Health Parity and Addiction Equity Act.

§155.400 Enrollment of Qualified Individuals into QHPs

We support proposed §155.400(g), which aims to prevent consumers from facing the consequences triggered for non-payment of premiums when only a de minimis amount is owed. We believe the provision will help ensure continuity of coverage, especially for lower-income enrollees. In addition, physicians in Texas have raised concerns related to the final 60 days of the grace period associated with advanced premium tax credits, when providers could be on the hook for incurred claims. Some physicians even cite the grace period associated with APTCs as a reason they do not participate in the networks of Marketplace plans. We believe that additional flexibility regarding when a grace period is triggered could reduce the frequency with which providers encounter patients in a grace period. To help further that goal, **we encourage CMS to clarify that if an issuer's payment threshold policy allows a consumer to avoid having coverage terminated for non-payment following a grace period as described in §155.400(g)(3), that the consumer be considered to have caught up on premiums, so that she can regain her coverage in good standing and be removed from the grace period.**

§155.725 Enrollment Periods Under SHOP

We support the goal of ensuring employees have adequate time to make coverage selections in the FF-SHOP, but believe that a minimum annual open enrollment period of just one week is insufficient. **The one-week minimum open enrollment period for employees should be longer.** Consumers enrolling in the FF-SHOP may need to compare several plans through the SHOP and then compare those choices to their spouse's job-based insurance offerings and/or Marketplace offerings. A one-week open enrollment period may not be enough time to make needed comparisons, get questions answered, and make selections.

§ 155.1000 Certification Standards for QHPs

We applaud CMS for considering active purchasing authority in order to provide consumers with high value, high quality plan options. In considering this new approach, **we recommend that CMS create a**

transparent process that considers input from a multitude of stakeholders, including consumer advocates and consumers, when identifying the standards on which plans will be selected. We agree, as noted in the proposed rule, that CMS could assess QHP performance based on compliance reviews and complaints from consumers. Input from stakeholders will be crucial to understanding QHP performance and past consumer experience.

Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

§ 156.20 Standardized Options

We support a standardized plan option and are pleased CMS is thinking about how to reduce consumers' burden in plan selection. However, **we urge CMS to make standardized plans, at least in the silver tier of coverage, a requirement for plans offering a QHP in an FFE in 2017**. At a minimum, CMS should design a strong incentive for issuers to offer standardized plans. **We recommend that CMS places standardized plans at the top of the Exchange website and delineates these plans from non-standardized plans in a way that encourages consumers to consider these standardized options.**

As proposed, the specialty drug tier for the standard silver plan has a 40% coinsurance responsibility for the enrollee. For individuals with chronic conditions who rely on costly medications for their treatment, a coinsurance of 40% would likely result in consumers rationing medication or forgoing it all together. Not only that, consumers have no ability to determine in advance what their monthly costs will be for a drug subject coinsurance. They are likely to find out their actual out-of-pocket costs only after they have enrolled in a plan and gone to the pharmacy to pick up their medication. Copays, on the other hand, allow consumers to understand what they will pay for drugs before they get to the cash register at the pharmacy. Therefore, **we urge CMS to adopt a copay, instead of coinsurance, for specialty drugs in standardized plans.** Requiring a copay would increase transparency and better allow a consumer to understand their potential financial liability in a standard plan. In the alternative, **we recommend that CMS lower the coinsurance to at least 20%.** This is currently the cost-sharing amount for the specialty tier in the Covered California standardized benefit design.

Additionally, we urge CMS to define "specialty tier" so that insurers do not place all expensive drugs in specialty tiers. The specialty tier was initially designed as a way to designate those drugs that required additional assistance (often from pharmacists) with the drug's administration. Even so, insurers have increasingly assigned this tier to many different drugs, seemingly to discourage usage, or to pass more of the cost of the medication onto consumers.

As proposed the standard plans do not offer a benefit design that is standardized across all EHB services. **We urge CMS to add all EHB services to the standard benefit design.** The major categories that are not specified include durable medical equipment, emergency transport, mental/behavioral health inpatient services, substance use disorder inpatient services, habilitative services, maternity care, and children's dental and vision services. It is misleading for shoppers to label a plan "standardized," yet to simultaneously have numerous non-standardized elements in each plan.

We support the proposal to limit standardized options to just one provider tier. This would not prevent insurers from offering tiered networks in their non-standardized plans.

We applaud CMS for making certain services exempt from the deductible in the proposed standardized benefits. The variability in what is exempted from the deductible across plans today makes effective plan comparisons difficult. CMS' proposal will help ensure that consumers can immediately afford certain care before a deductible is met and allow consumers to get "up-front" value for their premium dollars.

The proposed rule notes that CMS is considering limiting the number of plan options by issuer in future plans years to further simplify plan shopping for consumers. **This could be a helpful approach to simplifying shopping in some areas where meaningful difference requirements have not been effective enough.** For example, in Bell County, Texas, the 6 least expensive silver plans (of 19 total silver plans) are all offered by Ambetter. They are all EPOs. For a 30 year old, the plans vary by just $16 from least to most expensive, from $218 to $234 per month. While there are differences across the 6 plans, having to discern the sometimes small differences between six similarly priced plans with the same plan type from the same issuer adds unnecessary complexity.

§ 156.230 Network Adequacy Standards

In general, we applaud HHS for recognizing the need to strengthen network adequacy standards and for proposing a number of new protections that would apply for the 2017 plan year.

State Selection of Minimum Network Adequacy Standards

HHS seeks comments about using county-level time and distance standards, similar to those used in Medicare Advantage (MA). **In general, we believe that the MA standards, with their five geographic categories (large metro, metropolitan, micro-metropolitan, rural and Counties with Extreme Access Considerations (CEAC)) that account for geographic variations in provider accessibility and population distribution, would serve as an appropriate basis for QHP federal default standards**. We have advocated for MA as the standard at the state level as well. Texas' current standard, which has just two geographic categories (rural and non-rural) counts as adequate networks which can require travel up to 30 miles in an urban area to a hospital or primary care provider.

MA requires the use of minimum provider and facility ratios, in addition to minimum time and distance standards. **Therefore, we recommend that HHS also incorporate minimum provider/facility ratios in its standards for QHPs.** In addition, we recommend that CMS supplement the Medicare Advantage standards to account for differences between Medicare plans and QHPs in the covered population and covered services. In particular, **we suggest that CMS incorporate the use of 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.

In addition to time and distance standards and provider-to-covered person ratios, **we strongly urge CMS to set maximum appointment wait times for a wide range of services** including primary care, specialty care, urgent care for medical and dental services, urgent care for mental illness and substance use disorders, non-urgent mental and behavioral health services, life-threatening emergency care, and expanded practice access (including same day appointments for urgent needs and after-hours access to clinician advice). As an example, Texas network adequacy standards include wait time standards for urgent care, routine medical care, routine behavioral health care, preventive health care for children, and preventive health care for adults.

Regardless of what quantitative standards are used, **we urge CMS to provide greater scrutiny over the inclusion of specific provider types, particularly hospital-based physicians at participating hospitals.** This is a critical step to protect consumers from balance billing.

Texas law requires insurers to post data on both out-of-networks billing by and the network status of hospital-based physicians. We compiled the data from Texas' three largest insurer's PPOs last year, and the results were staggering.[1] We found that 41-68% of all charges for ER doctors are billed as out of the network despite the fact that care was delivered at a hospital that is in the network. For two of Texas' three largest insurance companies, about half of in-network hospitals have no available ER doctors in the same insurance network. In other words, it is very common in Texas, for a consumer to go to an in-network hospital in an emergency and get out-of-network care. Unfortunately, these situations are not just limited to emergencies. Up to 25% of all charges for anesthesiologists are billed as out of the network at in-network hospitals, and up to 38% of in-network hospitals have not a single in-network anesthesiologist available at the facility. While Texas has general network adequacy standards for HMOs and PPOs, we lack specific standards for hospital-based physicians, which contributes to making Texans vulnerable to surprise medical bills.

When determining network adequacy for 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.

Additional Network Adequacy Standards

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 support CMS' proposal requiring QHP issuers in all FFEs to notify enrollees about a discontinuation of an in-network provider as well as ensuring that enrollees have continuity of care protections when a provider is terminated without cause.

Allowing enrollees in active treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates in cases where their provider is terminated is an important step to minimize disruptions in care and ensure uninterrupted access to medically necessary services. However, **we believe that the 90-day transition period should be the minimum, rather than the maximum, length of time for patients being treated for a life-threatening condition, a serious acute condition, pregnancy, or another health condition (such as severe depression or a mental health condition) that would be worsened by discontinuing care by the treating health care provider**.

We strongly support allowing care for women in their second or third trimester of pregnancy to be extended through the post-partum period, commonly defined as the six weeks after birth, even though this may be longer than 90 days.

Providing a continuity of care transition period for new QHP enrollees, as CMS has previously encouraged QHP issuers to permit. Specifically, new enrollees in the midst of an active course of treatment should be

[1] Pogue S and Randal M, "Surprise Medical Bills Take Advantage of Texans: Little known practice creates a "second emergency" for ER patients," Center for Public Policy Priorities, September 15, 2014. Available at: http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf.

able to continue that treatment with their current providers for up to 90 days, even if those providers are not in their new plan's network. Given the proliferation of narrow networks it may be difficult for patients, especially ones in plans being discontinued and with complex health conditions, to find a plan that includes all of the specialists and other providers who treat them. These patients a need a sufficient transition period to allow them to find and make appointments with new health care professionals who participate in their new network.

We appreciate CMS's effort to put in place a provision to limit surprise bills to enrollees by requiring issuers to count the cost sharing charged to the enrollee for certain out of network services provided at an in network facility towards the enrollee's annual limitation on cost sharing. However, we believe that this is an inadequate protection. First, the provision appears limited to cost sharing, and does not require a balance bill to count toward the annual in-network deductible and out-of-pocket maximum, as Texas state law does for PPOs (28 Texas Administrative Code 3.3708(b)(3)). Furthermore, the proposal allows issuers to avoid responsibility all together by providing written notification to enrollees 10 days in advance that additional costs for an out of network service might be incurred.

To reduce the financial burden enrollees and/or their families might face at a time when they are most vulnerable dealing with sickness, **we strongly urge CMS to adopt stronger requirements to protect enrollees from unexpected balance billing by out of network providers.** We strongly believe that enrollees should be protected from and should not be subject to out of network cost sharing or balance bills in cases when they could not be reasonably expected to know or control whether care are being delivered by out of network providers. These situations include, but are not limited to:

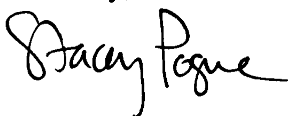
1. Unavailability of in-network providers for a covered EHB service;
2. Unexpected utilization of out-of-network care at an in-network facility for a covered EHB service;
3. Emergency care;
4. Out of network care as a result of an inaccurate provider directory.

We strongly encourage CMS to strengthen the remedy it proposes in §156.230(f). The proposal is significantly weaker than the provisions included in the NAIC's Model Act, which could be used as the basis for federal regulation.

We are enthusiastic about CMS's proposal to provide a rating of each QHP's relative network breadth on HealthCare.gov, and we strongly urge HHS to move forward with implementing this system. The rating system should be clear and concise for consumers to understand -- such as "small," "medium," and "large." In addition, CMS should consider providing separate ratings by categories of providers that would roll up to an overall rating of network breadth.

Thank you for consideration of our comments on this important rule. If you have any questions regarding these comments, please contact Stacey Pogue, senior policy analyst with the Center for Public Policy Priorities at pogue@cppp.org or (512) 320-0222 x 117.

Sincerely,



Stacey Pogue
Senior Policy Analyst