ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

February 25, 2014

Marilyn Tavenner
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Sent via e-mail: FFEcomments@cms.hhs.gov

Re: 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM)

Dear Ms. Tavenner:

Consumers Union submits this comment on the proposed draft guidance *2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM)* (hereinafter "Letter to Issuers") for the 2015 enrollment year. We appreciate the effort by CMS to create clear and transparent standards for QHP issuers. While we understand that in many cases the proposal applies only to the Federally-facilitated Marketplace, we indicate areas where the proposed standard should be a strong floor for all Marketplace policies.

CHAPTER 1: Certification Process and Standards for Qualified Health Plans

Rate Review (Section 3)

Consumers are paying an ever increasing share of health care costs and are heavily weighed down by health care and insurance affordability concerns. As they seek value in the insurance products they purchase, including from Marketplaces, QHP premiums are their first brush with costs as they make decisions about whether to buy coverage and, if so, from which issuer. Thus, oversight of QHP rates is critically important.

Rate increases (i)

We support CMS taking into consideration the actuarial justifications provided for rates as part of the certification process, as required by statute. However, we also urge communication with issuers and relevant regulators to learn if they find any of the actuarial assumptions, such as medical trend, questionable. In that way, issuers will have a chance to reconsider and revise their bids downward, as happens in states with and without prior approval authority. The result could be a more robust array of issuers participating in the FFM.

As noted in our comments to CMS on the rate review regulation in 2011, the processes and capacities among states deemed to have Effective Rate Review programs vary considerably. We urge CMS to recognize and monitor this closely such that while states' findings on rates are considered in certifying QHPs for the FFM, a state finding of reasonableness would not be deemed definitive. CMS should coordinate with state regulators, but also conduct an independent CMS review of the rate filing when state review processes are less robust – for example, when states lack the opportunity for public review of justifications or the capacity for actuarial review of steep increases.

According to federal statute and regulations, QHPs must prominently post online on the issuer's internet website all rate increases. However, the Letter to Issuers allows the rate justification to be posted online in one of two locations (the Marketplace website *or* the issuer's website). We recommend that CMS post *all justifications* on the Marketplace website to ensure consumers' ability to find this information. We urge the standardization of this important information on the Marketplace site to aid consumer understanding. Currently, information about rates on Healthcare.gov, even for those rates that are potentially unreasonable, is posted in very complicated formats that are inaccessible to consumers.

We strongly urge CMS to take into account rate growth inside and outside the Marketplace, from 2016 on, 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 cumulative effect of higher increases over time should be part of the review of increases in 2016 and beyond. In 2015, CMS should consider the historical pattern of rate increases for substantially similar products offered by the same issuer in the state and examine the breadth of the network for these products.

For 2014, it is our understanding that FFM rates were often approved before provider networks were submitted or even fully formed for a given plan, so that the accepted premiums did not take into consideration what level of access enrollees would have to various providers and specialties — a factor intrinsically tied to the premium rate and the given product's value to consumers. We therefore urge CMS to consider a product's provider network when considering if rates are justified and deciding whether or not to certify a given plan for the FFM.

Review of QHP rates (ii)

In sub-section (ii), 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 support the overall concept of an outlier analysis for each rating area. This would allow CMS to evaluate whether those on the higher end of the rate spectrum are justified and those on the lower end are geared at capturing market share only to jump significantly higher the next year or drop out. We encourage CMS to provide more detail on the criteria it will use to define

"outliers," and also to invite consumer advocates to work with CMS to determine the definition.

When an outlier is identified, the Letter to Issuers states that CMS will not duplicate a state's review of the plan's rates when determining if the plan should be certified and that CMS will collaborate with state regulators with Effective Rate Review programs. We support such coordination with state regulators, but also urge an independent federal review of the rate filing, a process for consumer input into that review process, and public posting of the outlier analysis. This independent federal review should give CMS authority to request additional information or clarifications from an issuer, rather than requiring it to rely solely upon the actuarial memorandum submitted by the issuer and any other information provided by the state's review process.

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

Service Area (Section 2)

We support CMS' review of service areas that serve a geographic area smaller than a county in order to ensure that issuers are not structuring very small service areas to avoid high risk populations or are acting in an otherwise discriminatory manner. We do not believe, however, that such reviews should be limited to regions smaller than a county. CMS should also review larger service areas to ensure that they are not structured in a discriminatory manner (for example, made up of parts of multiple counties or sub-parts of counties with the intention or impact of limiting the types of people who can enroll). CMS should ensure that all service areas are non-discriminatory, regardless of the service area's size or scope.

Network Adequacy (Section 3)

Consumers Union strongly supports rigorous requirements for 2015 regarding network adequacy. With narrower networks being used as a means to lower premium costs, and the creation of new insurance products such as Exclusive Provider Organizations (EPOs), which preclude any reimbursement to consumers who seek care outside of a designated network. ensuring a sufficient number of accessible providers and up-to-date, accurate understandable network information is more critical than ever. We fully support the requirement that QHPs submit a provider list as part of the QHP certification submission. In addition, we strongly support CMS' intent to create an integrated, searchable provider directory on the FFM that will permit consumers to learn which plans include their desired providers.

Provider Lists: We believe it is imperative that the Marketplaces (state-based and FFM) require QHPs to provide up-to-date provider lists that include all in-network providers and facilities for all products for which a QHP certification application is submitted. We also urge CMS to

require QHPs to submit terms of utilization for out-of-network providers, so that consumers in narrower networks can be fully informed of their rights and responsibilities. We applaud CMS' efforts to review the QHP submissions and closely focus on those areas that have historically raised network adequacy concerns (hospital systems, mental health providers, oncology providers, and PCPs) and to take action with the QHPs to resolve identified problem areas.

While we are enthusiastic about the provider list, we are concerned about timeliness of the list requirement. Given likely changes in provider networks during the certification process, we believe that there needs to be a requirement that QHPs update the provider list throughout the application process (and no less than quarterly once the issuer has been certified; see below) so that CMS and other regulators are able to view the most current provider network information. We urge CMS to require QHPs to update their provider list on at least a quarterly basis thereafter, to use common identifying language for providers (so the information that consumers see on the Marketplace matches what they find on the issuer's provider directory), and to implement consistent description or labeling for specialty areas of practice to make it easy for consumers to compare plan networks in the Marketplace.

Future Rulemaking: We also support CMS' proposal to undertake future rulemaking that would establish time and distance standards for plan networks while maintaining states' ability to implement stronger standards. At a minimum, QHPs should be required to identify and make public:

- Information about whether network providers are open to new patients;
- Languages spoken by staff and by the providers; and
- Average wait times to get an appointment.

New methods of communicating network adequacy to consumers should be tested, such as an overall indicator of whether a plan's network is narrow or broad. The patient's out-of-pocket costs if using an out-of-network provider should be illustrated, including the balance billing component. In addition, issuers should articulate the coverage policy for out-of-network providers when no providers are available in-network (including any cost-sharing limitations); and parameters that eliminate or restrict balance billing.

<u>Essential Community Providers (Section 4)</u>

Consumers Union strongly supports CMS' proposal to set a higher standard for QHPs to include at least 30% of Essential Community Providers (ECPs) in their provider networks. We suggest that the standard articulated in the draft Letter to Issuers also be applied to state-based Marketplaces as a floor, allowing state-based Marketplaces to set higher standards.

We believe that the requirement that plans include at least 30% of available ECPs in each service area will increase access to crucial providers of care for low-income and medically underserved enrollees. However, we believe that CMS' proposal to require issuers to offer contracts "in good faith" to all available Indian health providers in the service area and at least one ECP in each ECP category in each county in the service area does not go far enough in securing access to care for low-income or medically underserved enrollees. We look to CMS to craft guidance that will ensure that contracts with ECPs are not only offered, but actually entered into.

Patient Safety (Section 6)

Consumers Union strongly supports the requirement that QHP issuers must comply with new patient safety standards and may only contract with hospitals and health care providers that meet specified quality improvement criteria. Unacceptable levels of patient harm in hospitals have been well documented,[1] and this rule represents an important first step in requiring that QHPs contract with hospitals that have strong systems in place to prevent medical errors.

We have several concerns. The Letter to Issuers states, "Beginning on January 1, QHP issuers are required to comply with patient safety standards and may only contract with hospitals and health care providers that meet specified quality improvement criteria." However, it then indicates that the proposed regulatory requirements specify that these standards only apply to hospitals with more than 50 beds. We believe that the same safety standards should be in place for small hospitals and other health care providers, such as Ambulatory Surgical Centers. While there may be a call to adapt these standards to different environments, all providers caring for patients should be required to have quality assessment and performance improvement programs and discharge planning programs in place, not just hospitals with more than 50 beds.

Second, it appears that this section does not require states performing plan management functions to require compliance with these strong error prevention standards. We urge CMS to place these requirements on the "must do" list for states.

We look forward to providing additional comment on the forthcoming regulations.

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

Discriminatory benefit design (Section 1)

[1] U.S. HHS, Office of Inspector General. *Adverse Events in Hospitals: National Incidence among Medicare Beneficiaries*, November 2010. http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf

EHB Discriminatory Benefit Design (i)

Ensuring non-discrimination in benefit design is an extremely important consumer protection. CMS should establish a minimum non-discrimination standard that all states must apply and should retain the ability to review, monitor and enforce QHP compliance.

Moreover, we strongly recommend that CMS require states to report how they will review and monitor plans' compliance with EHB non-discrimination requirements and to issue the report publicly, including the state's plan and the outcomes of its monitoring and enforcement activities. The report should be submitted to CMS for review in addition to being posted publicly. Additionally, we believe that it is vital that CMS establish a clear process for consumers to file complaints about discriminatory practices and benefit design directly to CMS.

QHP Discriminatory Benefit Design (ii)

Even with strong non-discrimination regulations in place, QHP issuers may use marketing or cost-sharing structures to attract healthier individuals and dissuade higher-use consumers from enrolling in their plans. We applaud CMS' effort to take on a role in monitoring QHP issuers' activities by conducting an outlier analysis "comparing benefit packages with comparable cost-sharing structures to identify cost-sharing outliers with respect to specific benefits." CMS' scrutiny is important in protecting consumers from risk selection. We think creating this second layer of scrutiny to ensure that consumer cost-sharing structures are not discriminatory is important.

Even with standard EHB packages for each state, there is still potential for discrimination. Health insurance involves the use of complicated language which is not always readily understandable to consumers. Differences in cost-sharing can impact plan selection and consumers' utilization of benefits in ways that discriminate against patients with many or costly health needs. The list of specific benefits that CMS will turn its attention to is a good start. We would suggest adding additional benefits that warrant scrutiny, such as maternity coverage and the tier placement of drugs needed by patients with chronic illnesses.

We agree that CMS would do well to focus on the "explanations" and "exclusions" sections of the QHP package. We urge CMS to conduct detailed benefit design comparisons in order to identify designs that might be discriminatory and warrant additional review. CMS should leverage consumer scrutiny of these designs by conducting consumer-tested revisions to the *Summary of Benefits and Coverage* document. These revisions could highlight plan features that may under-serve patients with certain medical conditions, such as coverage examples that profile the cost-sharing that a person with an expensive chronic illness might experience.

Prescription Drugs (Section 2)

We strongly support CMS' proposal to require issuers to provide a direct URL to plan formularies and to include tiering and cost sharing information for covered drugs in the formularies. We agree that consumers should be able to browse the health-plan-specific formulary lists anonymously, without being asked to enter any log-in information before viewing. Clear and easily accessible information is an important factor in empowering consumers to make good decisions choosing a plan.

We urge CMS to ensure that the online formularies are clear and easy to distinguish from plan to plan. Of particular importance is a requirement that the plan names and drugs listed on the formularies are identical to the plan names and drugs listed on the Marketplace when consumers purchase a plan.

We also encourage CMS to consider creating a standardized display requirement or template for online formularies. A standardized display required of all plans would ensure that consumers could find the information they need to compare across plans and easily learn what drugs are covered and what drugs are not in each plan's formulary.

We encourage CMS to use consumer testing to add a formulary link to the *Summary of Benefits and Coverage* document, in the same way that a link to the in-network provider directory is provided and emphasized on page 1.

We also support CMS' intention to propose, through rulemaking, that Marketplaces require that issuers temporarily cover non-formulary drugs during the first 30 days of a new enrollee's coverage. CMS should clarify in its Letter to Issuers that during this period, enrollees will have access to non-formulary drugs without prior authorization or step therapy requirements. The guidance should explicitly ensure that temporary coverage will be available to those applying through a special enrollment period, not just during the open enrollment period. To that end, we recommend that CMS clarify in the Letter to Issuers that those who enroll outside of open enrollment will also have non-formulary drugs covered in their first 30 days of coverage. We also recommend that CMS make clear that this proposed guidance does not prevent states from adopting stronger standards.

Similarly, we urge CMS to adopt continuity of care requirements like those in place in states that require issuers to cover out-of-network costs for new enrollees for 90 days. Continuity of care requirements would ensure that, as consumers encounter new mobility between health plans, they are not penalized for changes in life circumstances or for switching to a plan that better suits their needs.

Supporting Informed Consumer Choice (Section 3)

Consumers Union has long noted the difficulties consumers face when making choices around health insurance. Purchasing health insurance is a difficult process for consumers, given the complicated terms and important financial and other implications of those decisions.[2] We appreciate the perspective that CMS has taken regarding the assessment of whether QHPs are offering "meaningful differences" amongst the products they sell in the FFM using a standard: "[w]hat would be required for a reasonable person to identify the differences in the characteristics of a plan." It is important that reviewers keep the consumer perspective foremost in their analysis of whether to flag QHPs for follow-up and review.

Consumers Union does not believe stand-alone dental plans (SADPs) should be exempt from the meaningful difference standards that will apply to QHP issuers. We believe SADPs should be assessed by the same standards set for QHPs. It is not clear, based on the Letter to Issuers, why SADP would be precluded from such an assessment. Many consumers already face confusion when they find that pediatric dental essential health benefits are not included in all QHPs. Ensuring that the products offered by one SADP issuer are meaningfully different from other SADP seems just as important as it is for QHPs.

Stand-alone Dental Plans: 2015 Approach (Section 4)

Consumers Union applauds CMS' decision to collect the average premiums actually charged by stand-alone dental plan (SADP) issuers and to evaluate the difference between these and the estimated rates provided by issuers on the rating templates portion of the QHP application. We believe that CMS should make this information available to consumers, and strongly recommend that it be made easily accessible online. Transparency of actual versus estimated rates is important to consumers and advocates, as is the opportunity to use this data to help inform potential standards for 2016 SADPs. Because SADPs are not subject to the same consumer protections as embedded plans, CMS faces an additional responsibility to ensure that these plans are treating consumers fairly.

Consumers Union continues to be concerned that consumers enrolling in SADPs lack the protections afforded to those obtaining pediatric dental benefits in embedded plans. SADP issuers may still discriminate based on pre-existing conditions, and are not required to adhere to annual and lifetime out-of-pocket maximums, leaves consumers vulnerable to the same practices which the Affordable Care Act's consumer protections were intended to prevent. We encourage CMS to consider application of stronger consumer protections for SADPs, as Covered

[2] L. Quincy & J. Silas, *The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making*, Consumers Union, November 2012; L. Quincy. *What's Behind the Door: Consumers' Difficulties Selecting Health Insurance*, Consumers Union, January 2012.

California has done, by incorporating these important consumer protections in agreements between the FFM and SADP issuers. We urge CMS to ensure that all consumers are treated equally in this regard by requiring the inclusion of consumer protections in agreements with SADP issuers for 2015 and communicating this in guidance to issuers. Such agreements should include, at a minimum,

- Guaranteed issue: the requirement that coverage be sold regardless of pre-existing conditions or health status;
- Limits on pre-existing condition exclusions or waivers;
- Prohibition against annual and lifetime maximums; and
- Modified community rating, which bases premiums solely on age, family size, and geographic region.

The absence of these protections directly affects the affordability of dental coverage, puts consumers at risk of racking up high out-of-pocket costs, and limits consumer choice through the potential exclusion of those with pre-existing conditions. We urge CMS to help ensure that the Marketplaces are in consumers' best interests by requiring SADPs to provide these fundamental consumer protections.

Primary care visits (Section 7)

Consumers Union strongly supports CMS' proposed requirement that plans cover three primary care visits that do not apply to the consumer's deductible. We believe that this proposal should apply to all health plans, not just one plan at each metal level. Introducing this uniformity with the coverage required by catastrophic plans and HSA qualified plans would reduce the benefit variation that consumers must contend with when shopping for a health plan and would provide valuable preventative care to consumers, an important factor in the early detection and treatment of medical conditions.

Chapter 4: Qualified Health Plan Performance and Oversight

FFM Oversight of Agents/Brokers (Section 4)

Consumers Union strongly urges CMS to prohibit agents and brokers from using "Marketplace" or "Exchange" in the name of their businesses or websites. CMS should identify the full extent of federal enforcement authority to prevent such confusion and use that authority to prohibit the use of such terms if possible. Such a prohibition would ensure that only the Marketplace operating in the given state (the FFM or the state-based Marketplace) could use these important terms.

Monitoring of Marketing Activities (Section 5)

We believe that CMS should establish some minimum standards with respect to what constitutes an adequate state review of marketing practices. CMS should make clear that its standards for state review of materials are merely minimum standards and that states may be more rigorous in creating their own standards.

We support CMS' review of QHP marketing materials in states where there is little or no existing review of materials. However, we urge CMS to provide in the Letter to Issuers a clear definition of the term "minimal review." What activities would meet the standard for minimal review? What activities will trigger CMS' engagement?

Further, Consumers Union supports CMS' requirement that QHPs include a standardized non-discrimination clause in QHP plans.

Chapter 6: Consumer Support and Related Issues

Provider Directory (Section 1)

Providing provider directories that are publicly accessible and organized in a way consumers can easily and effectively use is an important component of the Marketplaces. Updated and accurate provider network information, including information on which providers are accepting new patients, is vital to consumers' ability to make the best choice for themselves when picking a health plan.

We strongly support CMS' expectation that provider directories include:

- Location;
- Contact information;
- Uniform language that identifies the specialty;
- Medical group affiliations (including independent practice associations (IPAs), etc.);
- Any institutional affiliations;
- Languages spoken, identified separately for providers and staff; and
- Whether the provider is accepting new patients.

It is critical that these directories be specific to a given QHP benefit plan. States should have the discretion to require the inclusion of additional information that will educate consumers about providers in health plan directories.

We also urge CMS to establish a minimum requirement for regular updates to QHP provider

directories no less than once every quarter.

Complaints Tracking and Resolution (Section 2)

Consumers Union strongly supports CMS' expectation that QHP issuers thoroughly investigate and resolve consumer complaints received directly from members or forwarded by the state. We also support CMS' intention to track complaints and to use aggregated complaints information as a tool for directing oversight activities in the FFM. We suggest that CMS monitor the QHP complaint resolution process to ensure that investigations and resolutions are completed in a timely and accurate manner.

Meaningful Access (Section 4)

We are concerned that the Letter to Issuers fails to provide guidance clarifying the scope of protections for Limited English Proficient (LEP) individuals and the standards for ensuring that QHP issuers are providing meaningful access. In order to ensure that QHP issuers are meeting their meaningful access obligations, CMS should provide clear directions to issuers that outline the assistance they must provide LEP individuals. CMS should develop strong, detailed requirements to ensure that issuers are providing LEP individuals the opportunity to actively participate in and communicate with their health plans and health care providers.

We support CMS' intention to develop model notices to assist issuers in providing meaningful access for LEP speakers and people with disabilities. It is an efficient use of resources for one central entity to translate (including making web-based products compliant with Section 508 accessibility guidelines) and test these translations with consumers.

We would like to underscore the importance of testing these materials with consumers in their native languages, to ensure that the notices are understandable and that consumers are likely to act on the information. Furthermore, CMS should work with a representative sample of issuers to ensure that the resulting products will be used and that it is not difficult for issuers to customize the products for specific benefit plans. We urge CMS to make the model notices publicly available on the web and to publish its findings from consumer testing.

Summary of Benefits and Coverage (Section 5)

Consumers Union urges reconsideration of Letter to Issuer guidance suggesting that QHP issuers are not required to create separate Summary of Benefits and Coverage forms (SBCs) to reflect different levels of cost-sharing reductions for each plan variation. We strongly urge CMS to reverse this guidance and require that an SBC be provided for each cost-sharing variation.

From the consumers' perspective, a plan featuring cost-sharing reductions is a materially different plan from a regular Silver plan. If SBC documents are not required to accurately reflect this reduced cost-sharing, the utility and trustworthiness of the document will suffer. If the SBC reflects Silver level cost-sharing, rather than reduced cost-sharing levels, it actually misleads the consumer.

It is insufficient to "encourage" issuers to provide an SBC for each cost-sharing variation. Instead, we urge CMS to make this basic consumer protection a requirement — in other words, to require that the SBC accurately reflect the cost-sharing consumers will experience if they purchase the plan, including any cost-sharing reductions. We further urge that this guidance apply to all Marketplaces, both Federal and state. Finally, we support the prohibition against the combination of information about multiple plan variations in one SBC. We firmly believe that each cost-sharing variation must have its own SBC.

We appreciate the opportunity to comment on CMS' Letter to Issuers, which outlines important access and affordability consumer protections. If you have any questions or concerns, please contact Julie Silas at (415) 431-6747 ext. 106 or jsilas@consumer.org.

Sincerely,

Betsy Imholz
Lisa McGiffert
Lynn Quincy
Julie Silas