POLICY & ACTION FROM CONSUMER REPORTS

April 21, 2014

Center for Medicare and Medicaid Services
Department of Health and Human Services,
Attention: CMS-9949-P
P.O. Box 8012
Baltimore, Maryland 21244-1850

Submitted via www.regulations.gov

Re: File code **CMS-9949-P -** Patient Protection and Affordable Care Act: Exchange and Insurance Market Standards for 2015 and Beyond

Dear Secretary Sebelius:

Consumers Union, the policy and advocacy division of Consumer Reports, submits these comments regarding the proposed rule implementing insurance market rules and rate review.

We commend HHS and its agency partners in crafting provisions that strive to fulfill the promise of the Affordable Care Act (ACA) and promote strong consumer protections for applicants and enrollees seeking health insurance coverage. To that end, we see a number of laudable principles incorporated throughout the proposed regulations:

- **Consumer protections increasing access to Navigators** – By prohibiting state policies that would prevent Navigators from doing their jobs as envisioned under ACA's statute and regulations, HHS is ensuring that consumers across the country have access to individuals who are able to help them through the eligibility and enrollment process;
- **Special enrollment expansion** – to ensure all those with changing circumstances have access to health insurance coverage;
- **Transparent reporting on quality and enrollee satisfaction** – Requiring display of quality ratings that would allow consumers to view individual quality measures along with a global or summary quality rating, ensuring that consumers are able to effectively compare plans based on quality and enrollee experience.

In addition to the items that we welcome, there also are a number of provisions that we would like to comment on in detail below.

<u>Product Withdrawal/Modification (in Guaranteed Renewability Provisions - §146.152(f), §147.106(e) and §148.122(g)</u>

We support the proposed rule, which provides standards defining whether certain modifications constitute "uniform modifications" and therefore do not alter a policyholder's right to renewability. We believe that the regulations proposed here are essential in ensuring that the product withdrawal exception to the guaranteed renewability provision of the ACA is not used to subvert that provision and rescind coverage for certain consumers. We also believe that this proposed rule is important to ensure that issuers making modifications to plans undergo the rate review process, rather than use product withdrawal as a "loophole" to avoid scrutiny of higher rates.

We also support the proposal that the definitions of "uniform modification" proposed would pre-empt any conflicting state definitions; in particular the proposal that states may apply additional criteria that broaden

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the scope of what would be considered a uniform modification, but states may not impose criteria that narrow its scope. We believe this is an important allowance that ensures that states may enforce their own stricter consumer protections when it comes to guaranteed renewability of plans.

In addition, we strongly support the requirement that issuers provide 90 days notice to enrollees before withdrawing a plan from the market. We believe this provision is crucial in order to prevent gaps in coverage; both consumers and employers may need 90 days to find replacement health coverage.

Civil Money Penalties Consumer Assistance - §155.206

We support the proposed rule's overarching goal to balance protecting consumers from violations of Exchange standards by Navigators and other consumer assistance personnel with the need to avoid creating a chilling effect that discourages individuals and entities from becoming Navigators, non-Navigator assistance personnel or certified application counselors.

We also support the rule's expansive view of entities that could be targeted for enforcement for violation to include Navigators, non-Navigator assistance personnel, including federal contractors and certified application counselors. We believe the spectrum of organizations and individual engaged in Navigator activity should be accountable for violation of Exchange standards so as to protect consumers fully from a range of behaviors that could harm them.

That said, the monetary penalty could discourage participation in these assister programs for fear of the cost of defending against a claim, even if it turns out to be false. We therefore believe the use of CMPs as an enforcement mechanism should be significantly curtailed to address only egregious behavior. Rather, we believe the proposed rule's use of corrective action plans as a first step before assessing CMPs, as a way of working to correct Navigator violations of Exchange standards to ensure consumers are protected, while still providing ample access to Navigators, non-Navigator personnel, and certified application counselors.

At a minimum, Navigator entity concerns indicate the need for education and outreach for Navigators about CMP implementation in order to avoid discouraging participation from qualified organizations and individuals.

Consumers Union Recommendation: Limit use of CMPs to cases of egregious behavior, such as when the violation was the result of willful neglect, results in significant harm to a consumer(s), or when the entity refuses to comply with a corrective action plan.

Consumer Union Recommendation: Increase the time frame for response to a notice of investigation from 30 days to 60 days, to allow the entity to refute allegations, provided the entity or individual stops the behavior at issue, pending the outcome of the investigation.

Consumers Union Recommendation: Move the degree of culpability of the consumer assistance entity in §155.206(h)(2) to §155.206(h)(1) to require HHS to balance the degree of culpability of the Navigator among other factors listed in the section when determining non-compliance and and CMPs.

Consumers Union Recommendation: Exclude from the time frame for which a penalty is assessed the time that the investigation is being conducted, provided the entity or individual stops the behavior at issue.

Fixed-dollar Indemnity - §148.220 Excepted Benefits

Consumers Union supports the proposed rule to regulate fixed-dollar indemnity coverage of health care services and offer additional suggestions for further strengthening the rule. These plans, previously

referred to as "mini-med" policies, have created confusion for consumers who sometimes think they are purchasing comprehensive coverage, but in fact, have little protection for health care expenses.

We are concerned that fixed-dollar indemnity insurance products are proliferating in the marketplace. These plans do not provide insurance coverage, thus creating the opportunity for marketing abuses that could lead consumers to think these plans offer comprehensive coverage.

While there may be a role for fixed-dollar indemnity products as income replacement insurance that supplements comprehensive medical coverage, issuers must not be allowed to mislead consumers into believing that fixed-dollar coverage is adequate coverage —or in any way comparable to or a substitute for comprehensive health insurance. It does not meet the definition of minimum essential coverage.

While Consumers Union supports the restrictions found in the proposed rule, we encourage HHS to enact even stronger consumer protections. We believe the requirement that fixed-dollar indemnity coverage only be sold to individuals who already have minimum essential coverage does not offer sufficient consumer protection. There is a real danger that issuers will sell individual fixed-dollar indemnity policies to consumers as "barebones" group coverage, leaving them with inadequate coverage.

We are further concerned that the loose definition of "excepted benefits" includes plans that provide only preventive services. The proposed requirement that fixed-dollar indemnity plans only be sold to those with minimum essential coverage, under the current definition of excepted benefits, would allow some consumers to be sold fixed-dollar indemnity insurance as a wrap around to plans that offer only preventive services. As noted in the preamble, a group health plan providing minimum benefits can be considered minimum essential coverage. Evidence already exists that skimpy employer-sponsored plans that offer the ACA required preventive services are cropping up; a May 2013 article in *The Wall Street Journal* described the use of plans limited to preventive services as a strategy to avoid the employer responsibility requirement.

The availability of plans providing such limited benefits not only points to the need to limit the sale of fixed-dollar indemnity plans to people who have other coverage that meets the requirements for essential health benefits, but also to the need to further define excepted benefits. A plan that provides only preventive services provides no protection against the risk of illness or injury and should not be considered to be minimum essential coverage. An indemnity plan wrapped around a preventive services plan would effectively leave consumers without adequate coverage and thus exposed to serious financial risk in the event of hospitalization or a costly sickness.

Consumers Union further believes there is a need for strict regulation of the terminology that plans can use to market fixed-dollar indemnity insurance. We encourage HHS to provide guidance regarding permissible terms and descriptions for fixed-dollar indemnity plan marketing materials, such as a list of allowable names from which carriers of indemnity insurance may choose, so as to prevent companies from presenting these products in a misleading way, as if they were a form of health insurance.

Consumers Union Recommendation: Only permit issuers to sell fixed-dollar indemnity coverage to individuals who have essential health benefits coverage, or at the very least, those who have minimum value coverage of 60 percent actuarial value.

Consumers Union Recommendation: Require issuers to see and keep on file actual proof of essential benefit or minimum value coverage, such as a copy of an insurance card or policy, before issuing a fixed-dollar coverage policy. This imposes a minimal burden for the issuer, but is an important protection from the consumer.

Consumers Union Recommendation: Require issuers to warn consumers that fixed-dollar indemnity

coverage is not comprehensive health insurance, but supplemental insurance and meant to off-set out-of-pocket costs. Consumers should not only be given the warning included in the regulation, but should have to separately initial it.

Consumers Union Recommendation: Expand the definition of "excepted benefits" to include plans that provide only preventive services.

Consumers Union Recommendation: Prohibit the marketing by a single issuer of both minimum essential coverage *and* fixed-dollar coverage to the same individuals.

§155.210(c)(1)(iii) – Entities and Individuals Eligible to be a Navigator

As stated above, Consumers Union commends HHS for establishing standard rules that would prohibit state laws or policy that would serve to prevent consumers from obtaining access to needed help through a state Navigator program. We have long raised these concerns and are happy to see specific provisions that would ensure that consumers in all states are protected and able to access Navigator services. We think it is essential that all Navigators be required to provide fair and impartial information (subsection (A)); that all persons have access to Navigator services (subsection (B)); that Navigators cannot be prohibited from advising consumers about the benefits of different health plans (subsection (C)); that states cannot require agent or broker licenses or additional insurance that would have the effect of requiring such licensure (subsection (D)); and for the FFE Marketplace, that states cannot impose any restrictions that would prevent Navigators in those states from applying for and fulfilling the requirements of the ACA (subsections (E) and (F)).

We offer four suggested revisions to the proposed language to make the provisions in §155.210(c)(1)(iii) stronger.

Consumers Union Recommendation: Add language to §155.210(c)(1)(iii)(A) to be explicit that the impartial advice must be offered for the full range of QHPs: "Except as otherwise provided under §155.705(d), requirements that Navigators refer consumers to other entities not required to provide fair, accurate, and impartial information about the full range of QHPs.

For subsection (C), we very much appreciate the additional language that explicitly recognizes that Navigators will be providing "advice" to consumers about picking a plan that is right for themselves and their families. We think the language could be made stronger to ensure that the specific requirements of the Navigator program are included explicitly in the regulation.

Consumers Union Recommendation: Add language to §155.210(c)(1)(iii)(C) to ensure that the explicit duties of a Navigator (from §155.210(e)) are referenced in the provision: "Requirements that would prevent Navigators from providing advice regarding substantive benefits or comparative benefits of different health plans or prohibit Navigators from facilitating selection in a QHP."

Consumers Union Recommendation: Add similar language to the non-Navigator program §155.215 to ensure that states do not require that non-Navigator program personnel are required to be agents or brokers or impose restrictions such as errors and omissions coverage that would effectively require non-Navigators to be agents or brokers.

Consumers Union Recommendation: Add language to §155.210(c)(1)(iii)(E) to prohibit states from imposing financial fees or costs to a Navigator program that would effectively keep many community-based organizations from participating.

§155.210(d)(5)-(9) – Prohibitions on Navigator Conduct

Consumers Union supports many of the additional provisions proposed in §155.210(d) that ensure Navigator and non-Navigator personnel act in the best interest of consumers.

Consumers Union supports the proposed language prohibiting Navigators and non-Navigator personnel from charging fees or otherwise requesting or receiving remuneration for performing the range of required consumer assistance, outreach and education duties (subsection (5)). The intent of the ACA was that consumers would get free, unbiased assistance and information about coverage through the Exchange. This has special importance for lower-income consumers traditionally closed out of the private market and perhaps in greatest need of education about how insurance products work. Subsection (5) effectuates that intent.

Regarding subsection (6), Consumers Union recognizes that it is important not to create a Navigator program that will incentivize assistance for the easiest cases and disincentivize helping consumers with complex family or income circumstances, English language difficulties, or other reasons why assisting them might require more time to go through the eligibility and enrollment process. Since the Navigator program pays entities through a grant funded process, the prohibition proposed that would prevent Navigator entities from paying their Navigators per-enrollment or per-application makes sense and is something Consumers Union supports. For the non-Navigator provisions that prohibit per-application or per-enrollment payments, the solution is less clear. We have articulated our concerns as this provision would apply to non-Navigator personnel in our comments to §155.215 below.

In subsection (7), we agree that Navigators and non-Navigator personnel should not offer inducements including cash, gifts or gift cards to get people to apply for or enroll in health insurance coverage. We appreciate the recognition, however, that there may be instances where nominal gifts that assisters might provide (such as magnets) to promote the Marketplaces can be effective in reminding consumers about the Marketplaces and benefits of the ACA.

We also appreciate the intent of subsection (8) to avoid “cold calls” and door-to-door approaches that might be perceived as high pressure tactics to get applications started or enrollments accomplished. We believe the regulatory language, however, needs to be tightened and suggest some amendments below. We support the idea of barring door-to-door marketing by Navigators to have consumers fill out applications or enroll in coverage. Door-to-door marketing is a classic consumer concern, potentially imposing undue pressure on consumers in their homes. There is a history of abuses of door-to-door marketing in health programs, for example associated with California’s Medi-Cal Managed Care program.

At the same time, we recognize that some organizations have legitimately and effectively used door-to-door contact as a means of *outreach and education* for hard-to-reach populations. These activities are explicitly excepted in the preamble, and we recognize the utility of this approach for outreach and education. We urge CMS to make clear in the regulatory language the distinction between the ban on cold calls and door-to-door efforts for applications and enrollments on the one hand, and such activities for pure outreach and education which can advise people where they may obtain the application and enrollment assistance of their choice.

We believe a distinction should be drawn, as well, regarding the proposed ban in subsection (9) on robo-calls. While these calls can be annoying and disturb consumers’ tranquility and peace of mind if generated by an entity or person with whom they have no existing relationship, automated calls may be an efficient way to provide reminders from those with whom the consumer does have a relationship. Navigators, including health centers, may find automated calls an efficient way, for example, to remind an applicant about a scheduled appointment to complete an application or to provide missing documentation. We also presume that the proposed regulations would not prevent Navigator entities from using robo-calls for their other business activities (such as reminders for appointments at health centers). Since these

entities have existing relationships with their patients, this would not seem to carry the same concerns for consumers about the legitimacy or motivations of the organization. Consumers, however, should always have the right to opt-out of getting such calls from Navigators.

Consumers Union Recommendation: Amend §155.210(d)(8) and (9) as shown:

(8) Solicit any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling a consumer to provide application or enrollment assistance without the consumer initiating the contact. Navigator entities that have already begun an application for a consumer are not prohibited from door-to-door activity nor are they prohibited from using such means for activities that are solely for education and outreach.

(9) Initiate any telephone call to a consumer regarding assistance or enrollment in a QHP using an automatic telephone dialing system or artificial or pre-recorded voice, unless the Navigator entity or Navigator is already handling an application for the consumer.

§155.210(e) – Duties of a Navigator

The additional duties of Navigators are helpful in strengthening the relationship with consumers, both in requiring a written authorization (subsection (6)), but also for ensuring there is an avenue for consumers to obtain face-to-face assistance (subsection (7)).

For subsection (6), given the importance of ensuring that consumers have knowingly entered into relationships with individuals who provide them with assistance, the new provision that requires Navigators to obtain written authorization from consumers before accessing personally identifiable information (PII) is a good idea. While we understand that assisters have to retain a copy of the authorization for a certain amount of time to prove the authorization exists, there may be some confusion that the provision also might allow the authorization to be valid for the same length of time. It is important for HHS to clarify that the authorization is not effective for the length of time it is required to be retained (for example, FFE for three years), but has to be renewed between the consumer and the assister more frequently. Perhaps include some additional language that explicitly defines when an authorization expires and must be renewed (which is different from how long the assister has to retain the authorization in her or his files). We support similar provisions in §155.215(g) and §155.225(f)(2) that apply to non-Navigators and Certified Application Counselors (CACs).

Consumers Union Recommendation: Provide clarifying language that articulates that the authorization is valid for only X amount of time, though the form must by retained for three years. Perhaps establish the parameters for how long the authorization is good for and when it needs to be renewed.

§155.215 – Non-Navigator personnel

Based on §155.215(a)(2)(i), non-Navigator assistance personnel funded through an Exchange Establishment grant must comply with Navigator conduct set forth in §155.210(d) including the proposed prohibition on per-application or per-enrollment payments.

As you are aware, the state of California has long relied on certified assisters to help applicants enroll in health coverage programs, paid on a per-application or per-enrollment basis, with great success. Covered California had enrollment success during the first ACA open enrollment period, covering more than 3 million people using, in part, this per-enrollment payment system. However, California pays non-Navigators only when a successful application is submitted, does not compensate non-Navigators for the variety of services that they provide to consumers in addition to the successful completion of an application, and pays amounts that everyone recognizes are insufficient to the task. We have urged, and

continue to urge, greater payment amounts for application assistance. Since the FFE does not have a compensation program for non-Navigators, we aren't sure what the most effective alternative models are and how they would work in states like California that pay per-enrollment or per-application.

Nonetheless, it may make sense to shift to an alternative payment method. Neither a pure per-application or per-enrollment, nor a pure salary method without per-enrollment measures, may achieve the desired result: securing enrollments, handling complex cases, adequately compensating non-Navigators for the many facets of assistance, including post-application document gathering, premium payment questions etc. We suggest that CMS explore a hybrid approach; the system we understand exists in Washington State. In that state, and perhaps others, a grant or salary-based approach is combined with outcome-based incentives. In this way, Navigator and non-Navigator personnel have assured revenue to enable organizational planning, hiring and stability, but CMS provides strong incentives to enroll more people or to deal with harder to handle cases.

Consumers Union Recommendation: We recommend that the prohibition against per-enrollment or per-application payments to non-Navigator assistance personnel include flexibility to allow states using the per-application or per-enrollment payment method more time to come up with alternatives and any required transition.

§155.225 – Certified Application Counselors

Many of the important provisions that are proposed for Navigators are proposed for the Certified Application Counselor (CAC) program in these regulations. In most instances, our comments articulated above about the provisions in the Navigator program apply equally to the CAC regulations, including:

- (b)(1)(iii) – support the proposed regulation that provides the opportunity for consumers to obtain face-to-face consumer assistance from CACs, as well as Navigators and non-Navigator personnel.

- (f)(2) – support the requirement of a written authorization before accessing personally identifiable information (PII) and note our comments to §155.210(e)(6).

- (d)(7) – support annual recertification of CAC personnel, as proposed.

- (d)(8), we think the language for CACs should mirror the language in the proposed Navigator provisions. Hence, our line edits for 155.210(c)(1)(iii) noted above would apply to these provisions, as well.

We are concerned that at least one provision that applies to the Navigator program does not apply to the CAC program in these proposed regulations, namely, the provision that prohibits state laws that would require Navigators to be agents or brokers or have errors and omissions coverage. Like the Navigator program, states should be prohibited from requiring that all CACs must be agents or brokers.

Consumers Union Recommendation: Include language mirroring §155.210(c)(1)(iii)(D) to the CAC program to ensure that states do not require that CAC personnel be agents or brokers or impose restrictions such as errors and omissions coverage that would effectively require CACs to be agents or brokers.

Civil Money Penalties - False or Fraudulent Information - §155.285

HHS proposes imposing CMPs for three types of actions related to the provision of false or fraudulent information or the misuse of information: CMPs for false or fraudulent info provided due to "negligence or disregard" of regulations; CMPs for false or fraudulent info provided "knowingly and willfully," and CMPs

for the knowing and willful use or disclosure of information in violation of ACA section 1411(g), which states that applicant information may be used only for the purposes of ensuring efficient operation of the Exchange.

We support the proposal that HHS take into account a variety of factors when determining the amount of CMPs to impose, including the nature and extent of the harm resulting from the action. We believe these provisions will further ensure that consumers who unintentionally provide false or fraudulent information to an Exchange are not unfairly penalized and that CMPs appropriately reflect the seriousness of a particular misrepresentation. Additionally, we believe that, similar to what is proposed in section §155.206(a)(2), HHS should include in regulations the option for persons who provide false or fraudulent information to an Exchange to enter into a corrective action plan to correct the violation.

Given that Navigators, non-Navigator personnel, and certified application counselors are not actually providing information in the process of an application for coverage or an exemption, but simply relaying information provided by consumers, we suggest that the more appropriate provision to govern Navigators and other assister personnel and any violations should be §155.206.

Consumers Union Recommendation: Include language mirroring §155.206(a)(2) to section 155.285 (d)(1) to create the option for a corrective action plan for persons who may be subject to a CMP under §155.285(a)(1).

§155.420 – Special Enrollment Periods

Consumers Union appreciates the recognition that not all special enrollment triggers are the same. We support HHS' effort to create unique rules for some special enrollment triggers that would ensure people don't have to wait before getting insured (§155.420 (b)(2)(i)), for example, when a new child is added to the family through birth or adoption. We also support in this same provision the recognition that a consumer could elect later coverage.

Another important example of that flexibility is to allow consumers who are newly eligible through a special enrollment because of marriage or loss of minimum essential coverage (§155.420 (b)(2)(ii)), to elect to start coverage the first day of the following month, regardless of whether they apply before the 15th of the month or after, just as occurs in the employer-sponsored group market.

We also appreciate the new allowance for consumers to become eligible and enroll in new coverage 60 days before the triggering event actually occurs, when the triggering event is loss of coverage from an employer-sponsored health plan (§155.420 (c)(2)). This proposed provision will better ensure that people losing ESI have no gap in coverage.

We are concerned, however, that some of the other triggering events create no floor for Exchanges to abide by, but simply provide flexibility to states to define the length of the special enrollment period. (§155.420 (c)(3)). We note that HHS has suggested it will issue guidelines by which states will have to abide. We highly recommend that HHS establish a floor for states, but provide flexibility for states to provide more protections for consumers. We think in no instance should states be allowed to create special enrollment periods that are less than 60 days.

Consumers Union Recommendation: Modify §155.420(c)(3) to read: "In the case of a qualified individual or enrollee eligible for a special enrollment period as described in paragraphs (d)(4), (d)(5), (d)(9) or (d)(10) of this section, the Exchange may define the length of this special enrollment period as appropriate based on the circumstances of the special enrollment period, in accordance with guidelines issued by HHS, but it should be nothing less than 60 days.

Under subsection (d) we support newly proposed provisions that recognize special enrollment triggers should be provided to qualified individuals and their dependents mid-year when they lose minimum essential coverage, even when there is the option to renew (subsection (1)) or to qualified individuals and their dependents newly eligible for tax credits who previously were enrolled in an employer-sponsored plans but are no longer eligible for that plan as result of employer changes in policy of available coverage (subsection (6)(iii)).

Despite the special enrollment period provisions already in place and those in the proposed rule, we are concerned that some consumers may be left out – in particular, those whose income changes outside of the open enrollment period and therefore results in new eligibility for advanced premium tax credits. For example, some consumers in states that have not expanded Medicaid who fall into the "coverage gap" (that is, whose incomes are too high to qualify for Medicaid but too low to qualify for tax credits) may, outside of the open enrollment period, experience an increase in income that renders them eligible for tax credits. Equally, some consumers originally ineligible for APTCs may have enrolled in coverage outside the Marketplace but later have a change in income that would make them eligible for APTCs. Consumers who experience this and other changes in income that do not already trigger special enrollment periods – for example, a job loss (where the consumer was not enrolled in coverage through his or her employer) – should have the option to enroll in a Marketplace plan and take full advantage of available financial assistance, instead of having to go uninsured or purchase an affordable plan off of the Exchange without the APTCs they eligible for, until the next open enrollment period.

Consumers Union urges HHS to include a provision that would allow for a special enrollment period for these consumers.

Consumers Union Recommendation: Add language to §155.420(d)(6) to read: "A qualified individual or his or her dependent has a change in income or tax household composition or tax household size resulting in a determination that he or she is newly eligible for advance payment of premium tax credits."

§155.1400 - Quality Rating Display Requirement

Consumers Union supports the proposed regulatory provision that requires Exchanges to prominently display quality ratings information on their websites for each QHP. We appreciate that CMS intends to outline criteria for public display of quality rating information in future guidance and emphasize the importance of ensuring that the display of this information is easy to understand and consumer-friendly.

We support CMS' flexibility and encouragement of state innovation in reporting and displaying health plan quality and outcomes data. For example, states may require display of additional quality ratings to ensure consumers have access to robust quality information when shopping for plans. We emphasize the importance of display criteria that ensure consumers are able to use this information in an effective way.

CMS requests comment on the possibility of allowing state Exchanges to include a link to the FFM site's quality ratings display to satisfy the quality rating data display requirement. We are concerned that only having quality ratings displayed on the FFM will hinder consumer access to this information at the time they are making plan choices. Consumers may not take the time or understand that they need to click through to view quality rating data. Instead, Consumers Union urges CMS to require state exchanges to display quality rating data directly on state exchange websites. Consumers should have ready access to quality rating data when choosing a plan, regardless of what state they live in.

§155.1405 - Enrollee Satisfaction Survey Display Requirement

Consumers Union also supports the proposed provision that requires Exchanges to display Enrollee

Satisfaction Survey (ESS) or “Customer Experience” results on their websites. In the preamble to the proposed standards, CMS states its intention to incorporate enrollee experience data from the ESS results into the global quality rating for each QHP, while allowing consumers to “drill down” to the results for individual quality measures, including enrollee experience data. We appreciate CMS’ understanding of the importance of synthesizing and simplifying health plan quality information to improve consumer understanding, while also allowing consumers to view more specific information related to their own priorities when choosing a plan. We support both the simplified display and opportunity to view details of the ESS, and would oppose any effort to provide only the ESS information as the permanent solution in the global quality rating.

We also support CMS’ proposal to allow state Exchanges to display all ESS results on their websites, including scores not used as part of the QRS. However, we urge that Exchanges be required to allow public access to that detailed information. In addition, as with all quality rating information, states should be required to adhere to a set of display criteria, as mentioned above. CMS states in its standards that it seeks comment on whether State Exchanges should have flexibility to display ESS beta test results prior to the scheduled public display of the Federal ESS in 2016. We believe allowing states to display these results would give consumers more timely, better access to important quality information. We suggest that CMS require states to indicate that the displayed data represents results from a “preliminary 2015 test,” and that later, more robust data will be forthcoming.

HHS seeks comment on its proposal to incorporate enrollee experience data from the ESS results into the quality rating for each QHP. While we agree that incorporating ESS data into quality ratings may improve consumers' ability to effectively evaluate plan quality, we strongly urge HHS to require Exchanges to also separately display on their websites the ESS scores, including *all* available ESS data, even scores not used as part of the quality rating.

The Enrollee Satisfaction Survey is a powerful tool for empowering consumers to make informed decisions while purchasing or shopping for a plan through an Exchange website. Consumers may be interested in particular pieces of data--for example, how well the plan handles grievances or how well its doctors communicate discharge plans. They should have the ability to drill down to view *all* ESS data, not just that which is included in a plan's quality rating. Including only partial ESS data would prevent consumers from having access to all the information they need to make decisions about their health care and could convey a false impression.

Consumers Union Recommendation: Amend language at §155.1405 to read “The exchange must prominently display ***all*** results from the Enrollee Satisfaction Survey for each QHP on its website, in accordance with §155.205(b)(1)(iv), as calculated by HHS and in a form and manner specified by HHS.”

Prescription Drug Formularies- §156.122

We support the goals of the rule to improve timely access to drugs for enrollees with certain complex medical conditions through an expedited process for appeals under exigent circumstances. We share concerns that enrollees have timely access to specific non-formulary drugs where needed.

We support amending the formulary exceptions standards to expedite these processes when an enrollee is suffering from a serious health condition or is in a current course of treatment where interchanging a drug would have a negative clinical consequence on an enrollee. There may be situations where it is clinically appropriate for a patient to continue on a non-formulary drug. Examples include patients who have been stabilized on particular anti-epileptic, anti-psychotic or anti-coagulation regimens, where abrupt discontinuation or changing of therapies could result in acute deterioration of health. On the other hand, often there is little clinical risk associated with immediately changing to a formulary alternative, as in the case of ulcer medicines and many blood pressure medicines.

While a 24-hour turnaround for appeal in emergency cases is ideal, it may not be realistic. However, at least a preliminary decision should be required within 24 hours. For example, some state Medicaid programs require prior authorization within 24 hours, but have an administrative appeals process that could take much longer. If there is a gap between the initial and final determination, enrollees should be provided the non-formulary drug at issue until the final appeal is resolved.

Consumers Union Recommendation: The new expedited appeals procedure should have processes in place for identifying and accommodating clinical situations where changing or stopping a non-formulary drug puts an enrollee's health at risk.

Consumers Union Recommendation: The appeals procedure should require coverage of the drug at issue, pending the resolution of the appeals process.

Consumers Union Recommendation: At least a preliminary decision should be made within 24 hours following an issuer's receipt of the formulary exception request.

Consumers Union Recommendation: The final determination of an expedited appeal to a formulary exception should eventually be appealable to an independent review organization with binding authority.

Consumers Union Recommendation: The expedited appeal procedures for exigent cases should allow for appeal of use of non-formulary drugs, as well as appeal of tiering and other cost sharing measures.

Cost-sharing - §156.130

Consumers Union supports CMS' proposal to round limitations on cost-sharing to the multiple of 50 dollars that is lower than the number calculated by the formula in order to calculate the premium adjustment percentage that is used to find maximum cost-sharing requirements. Rounding down as opposed to up aligns with rounding rules used by the Department of Treasury and the Internal Revenue Service, creating a congruency that is in the best interest of consumers.

We suggest that the language used in the preamble of these proposed regulations that lays out the calculation should be added into the regulations. The language states that *the premium adjustment percentage is calculated based on projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditure Accounts (NHEA), which are calculated by the CMS Office of the Actuary*, which will result in the stated calculation of a premium adjustment percentage of 4.213431463 percent for 2015. This will result in a 2015 maximum annual limitation on cost sharing of $6,600 for self-only coverage and $13,200 for other than self-only coverage, and a 2015 maximum annual limitation on deductibles of $2,050 for self-only coverage and $4,100 for other than self-only coverage.

Consumers Union Recommendation: Add language to §156.130(e) to read: "The premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. The premium adjustment percentage is calculated based on projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditure Accounts (NHEA), which are calculated by the CMS Office of the Actuary. HHS will publish the annual premium adjustment percentage in the annual HHS notice of benefits and payment parameters."

§156.1120 - Quality ratings system

Consumers Union supports CMS' suggestion to develop a Quality Rating System (QRS) applicable to other Marketplace offerings, including stand-alone dental plans, in addition to one for full QHPs. This would be an important mechanism that would aid consumers spending their scarce resources for

additional coverage. We look forward to the opportunity to comment on the quality measures to be used for these additional quality ratings.

CMS notes in the proposed standards that a limited number of child-only QHPs may prohibit reliable quality information for these plans. We encourage CMS to require submission of the data that is available for these plans and to calculate and display quality measures for which data is available. Rather than including no quality ratings for child-only plans, CMS should display the data that is available, even if there is not enough data to display a global rating. CMS should require Exchange websites to indicate when a rating or specific measure or domain is not displayed because of low enrollment or insufficient data.

We look forward to commenting on the finalized quality measures for calculating quality ratings and details on measure specifications in future guidance. As stated in our January 2014 comments on CMS-3288-NC: "Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System Framework Measures and Methodology," Consumers Union has some concerns about CMS' proposed quality measure labels and names. In our previous comments, we offer suggestions for how to make these names more consumer-friendly. We also suggest the inclusion of stronger measures of patient safety, network adequacy, and overall out-of-pocket costs. We encourage CMS to look to our previous comments in creating future guidance on quality measures. We look forward to providing more detailed recommendations on quality measures when future technical guidance is released for public comment.

§156.1120(a)(3)

In the proposed standards, CMS states it intends not to require quality rating data by metal level for initial years. We are very concerned about this proposal, as not all QHPs are offered at all levels in the Exchanges (for example, in California, one issuer offers a PPO at the bronze level only, while offering an HMO at the silver, platinium and gold levels). We strongly recommend rapid movement toward requiring metal level quality rating information. It is important that this information be available to consumers who need to make complicated decisions about cost and value when choosing between different tiers and quality rating is an important part of that choice. We encourage CMS to gather data on quality measures by metal level where available. If CMS does not adopt our recommendation, we urge the adoption of a requirement that Exchanges indicate, when quality ratings are displayed with a plan on an Exchange website, that the quality ratings displayed represent aggregate data for that product overall, and not for the specific metal level of the given offering.

156.1120(c)

In CFR §156.1120(c), CMS states its intention to allow issuers to reference quality ratings in marketing materials in a manner specified by CMS. While we appreciate that these ratings are useful in helping consumers compare plans, the potential for abuse and misrepresentation of the ratings in marketing materials is significant. Absent a review process for marketing materials, and given that CMS is considering not requiring ratings by metal level, we believe that issuers should *not* be allowed to use these quality ratings in marketing materials.

Consumers Union Recommendation: Delete language at 156.1120(c) reading "a QHP issuer may reference the quality ratings for its QHPs in its marketing materials, in a manner specified by HHS."

§156.1125 - Enrollee satisfaction survey system

Under Section 1311(c)(4) of the Affordable Care Act, HHS is required to implement an enrollee satisfaction survey system to assess the level of satisfaction of members of each QHP in the Exchange.

We believe the ESS – and the availability of ESS data to consumers on Exchange websites – is a crucial element of ensuring transparency and empowering consumers to make informed decisions when shopping for a plan.

§156.1125(a)

We encourage CMS to develop an ESS survey to specifically assess the experiences of consumers with child-only plans, such as pediatric dental.

§156.1125(c)

Regarding CMS' proposal to allow issuers to use ESS survey results in marketing materials, we reiterate our above comments on the proposal to allow issuers to use quality rating data in marketing materials.

§158.150 et. seq. – Medical Loss Ratio

Though we recognize the justification for flexibility in allowing insurers to temporarily include an increase to their incurred claims and quality improvement expenses, we strongly urge CMS to limit this allowance to one year. This adjustment to the medical loss ratio calculation directly impacts consumer rebates and may negatively impact insurance premiums.

We continue to believe that ICD-10 conversion expenses are purely an administrative expense and it is not appropriate to include these expenses as quality improvement. As previously noted in comments from Consumers Union, claims processing is a core administrative competency and a key component of an insurance product. Conversion to a world standard data coding classification system does not make this activity a quality improvement activity (QIA) as defined in the ACA or the MLR definition.

We acknowledge that the ICD-10 conversion process can improve health plans' ability to share data, thus potentially improving treatments. However, the data coding classification system in and of itself only provides the infrastructure to more accurately code the delivery of care and facilitate appropriate and accurate claims payment. Other initiatives are required to analyze or measure health outcomes, such as the activities contained in the current QIA definition. Furthermore, the decision to extend the inclusion of ICD-10 implementation expenses as quality improvement should at a minimum be limited to those insurers that can demonstrate they require additional time to adopt ICD-10. The proposed extension to include ICD-10 in QIA is in effect an incentive for insurers to further delay complete adoption of ICD-10.

We are also very concerned about simply tying the extension of this leniency for including ICD-10 to implementation expenses to the end of the implementation period, regardless of any further delays. If the implementation period continues to be extended then the inclusion of expenses as QIA will be an incentive to delay ICD-10 adoption.

On behalf of Consumers Union, we welcome the opportunity to comment on these important regulations and realizing the full promise of the Affordable Care Act.

Sincerely,

DeAnn Friedholm

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Consumers Union