December 22, 2014

Secretary Sylvia Mathews Burwell
Department of Health and Human Services
Attention: CMS-9944-P
P.O. Box 8012
Baltimore, Maryland 21244-1850

Submitted via www.regulations.gov

Re: **CMS-9944-P: Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016**

Dear Secretary Burwell,

Consumers Union, the policy and advocacy division of Consumer Reports,[1] submits these comments regarding the proposed rules implementing benefit and payment policies.

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:

- **Guaranteed Availability - Special Enrollment §147.104 (by reference to Section 155.420(d))** We support extending the availability of the special enrollment period for a qualified individual and his or her dependent who, in any year, has coverage under a group health plan or individual health insurance coverage that is offered on a non-calendar year basis.
- **Guaranteed Availability - Triggering Events §147.104(b)(4):** We support allowing an individual 60 days before and after certain triggering events to make a plan selection through or outside the individual market Exchange.
- **Guaranteed Availability - Change Of Issuer §147.106:** We support codifying the idea that an issuer does not satisfy the requirement to offer other coverage currently being offered "by the issuer" in the applicable market if it automatically enrolls a plan sponsor or individual into a product of another issuer that is separately licensed to engage in the business of insurance in a State.

[1] Founded in 1936, *Consumer Reports* is an expert, independent, nonprofit organization whose mission is to work for a fair, just, and safe marketplace for all consumers. Using more than 50 labs, its auto test center, and survey research center, the non-profit organization rates thousands of products and services annually. Consumer Reports has over 8 million subscribers to its magazine, website, and other publications. Its policy and advocacy division, Consumers Union, works for health reform, food and product safety, financial reform, and other consumer issues in Washington, D.C., the states, and the marketplace. This division employs a dedicated staff of policy analysts, lobbyists, grassroots organizers, and outreach specialists who work with the organization's more than 1million online activists to change legislation and the marketplace in favor of the consumer interest.

- **Part 154 - Health Insurance Issuer Rate Increases:** Disclosure and Review Requirements-General Provisions: We support many of the proposals included in this section and encourage HHS to apply them as soon as possible. Given that many of the provisions will be established well in advance of mid-2015 filing requirements, we believe States and issuers will have sufficient time to transition to the new rate review time frame and consumers need not wait another year to benefit from an improved rate review process. See our detailed comments on Part 154 below.
- **Disclosure And Review Provisions - Rate Increases Subject To Review (§154.200):** We support the technical correction to the text of paragraphs (a)(1) and (2) to clarify that the 12-month period for rate increases begins on January 1 rather than September 1. This technical correction brings the regulations in line with the reality that rate review evaluates rates that are set for the established January through December calendar year.
- **Submission Of Rate Filing Justification (§154.215(a)):** We support this improved language, which ensures that carriers submit rate filing information down to the plan level, aligning the level of review with the actual plan consumers shop for and enabling regulators and consumer advocates to better scrutinize carriers' filings for upcoming plans years. We also applaud HHS' intent to make this improved language effective upon finalization of this rule.
- **Definitions (§155.20):** We appreciate the explicit addition of dependents to the definitions of "applicant," "enrollee," and "qualified employee" to make clear that the benefits accrue to dependents for both the individual and SHOP markets.
- **Consumer Assistance Tools And Exchange Accessibility (§155.205(c)(2)(i))**: We support the proposal to require agents, brokers and QHP issuers to provide oral interpretation, which includes telephone translation, in at least 150 languages.
- **Enrollment Of Qualified Individuals Into QHPs (§155.400) -** We support HHS' proposal to require payment of the first month's premium by the coverage effective date for enrollees in the Federally-facilitated Marketplace (FFM). This extended payment deadline is an improvement from the previous rule and provides crucial flexibility to enrollees.
- **Special Enrollment Periods (§155.420)** - We appreciate HHS' proposed expansion of special enrollment triggers to include "misconduct" on the part of QHP issuers, and to allow for consumers in non-Medicaid expansion states to enroll when their income changes during the year. We also appreciate the flexibility in effective dates for special enrollment for permanent moves and court-triggered events.
- **Data Reporting on Benchmark Plans (§156.120)**: We appreciate adding a specific provision that requires data reporting on base benchmark plans, so that it is easy for consumers and advocates to understand variations in coverage across states.
- **Non-discrimination (§156.125)**: We applaud the preamble language that makes clear to issuers that benchmark plan designs that impose limits or exclusions that discriminate are prohibited. Moreover, we support the preamble's admonition that placing most or all of the drugs for a specific condition in the highest cost-sharing tier effectively discriminates against, or discourages enrollment by, individuals who have that condition. We believe there should be stronger oversight by HHS and the Exchanges to ensure that all QHP issuers adhere to the Affordable Care Act's non-discrimination provisions.

- **Flexibility on Out-Of-Pocket Maximum (§156.130(c)):** We appreciate HHS' preservation of the ability for issuers to continue to count out-of-network costs towards the out-of-pocket maximum.
- **Plan Suppression (§156.815)**: We support the proposal to suppress QHPs from being offered through the FFM under certain circumstances, such as when there is pending state enforcement action that could affect the issuer's ability to enroll consumers. We hope that the state-based Exchanges are provided a similar ability to suppress QHPs, with the flexibility to create additional plan suppression criteria.
- **Treatment Of Cost Sharing Reductions In MLR Calculation (§158.140(b)(1)); Reporting Of Federal And State Taxes (§158.162(a)(2) and (b)(2))**: We support amending these provisions to clarify various data points in MLR calculation.

In addition to the above items, there also are a number of provisions for which we provide more detailed comments below.

§147.106. Guaranteed Renewability of Coverage

CMS asked for comment on how to structure guaranteed renewability requirements in the context of corporate transformations involving a change of ownership, such as mergers, acquisitions, and similar business restructuring. In these cases, CMS suggests allowing transfer to another issuer only if the same benefits, network, and other coverage features remain in place and the acquiring issuer agrees to accept liability for any payments and charges for the advance payments for the premium tax credit, cost-sharing reductions, the FFE user fee, and the HHS-operated risk adjustment, reinsurance, and risk corridors programs. Specifically, CMS asks what types of automatic enrollment practices should be permitted in connection when these types of corporate transactions occur.

The overarching principle for CMS should be to hold the consumer (i.e. enrollees) harmless. If the new corporate owner has essentially taken on the entirety of the policy contract between the enrollee and the former issuer, with no changes in cost-sharing benefits, covered services, provider network or drug formulary, and the enrollee(s) will receive credit for all cost-sharing already paid during the plan year (i.e. progress towards deductible and out-of-pocket maximum), then we recommend:

- HHS should require the issuer to provide a consumer-tested, plain-language notice to the enrollee that notifies them of a special enrollment option (describe how) OR, as a default, the option to stay in the new issuers' plan. The notice should confirm that all aspects of their policy, including cost-sharing benefits, covered services, provider network or drug formulary remain the same, where to find this complete description online, and a number to call for more information.

If the above conditions are not met, and there are changes in cost-sharing benefits, covered services, provider network or drug formulary for the enrollee, then:

- HHS should require the issuer notice include the bold headline "Your health plan benefits are changing. This entitles you to a special opportunity to enroll in a new plan between

[date] and [date]. Free, in-person assistance is available to help you. Call xxx-xxx-xxxx." As with the other model notices promulgated by CMS, the notice must continue with a complete description of how the benefits are changing.

§154.102 Definitions

We support CMS' enhancement to the definition of "plan" so that proposed health insurance rates are reviewed at the level of granularity that consumers buy them. For example, a plan like the (fictional) Jump America Bronze Co-pay PPO will be evaluated apart from their Silver $10 Co-pay PPO. By separating out plans based on cost-sharing structure, provider network, and service area–thus aligning with details that consumers shop for–regulators will gain a more accurate picture of what is offered to consumers and at what cost. The current lack of a federal definition for "plan," and subsequent lumping of divergent plans under a shared "product" umbrella makes targeted rate review challenging. For these reasons, we strongly support the proposed definition of "plan" as proposed in §154.102 and §144.103 and detailed in section III.A.1.a of the preamble to this NPRM.

§154.200(c) Rate Increases Subject to Review

Comprehensive review of rate filing justifications (RFJs) has important implications for consumers; it is the only way to ensure that consumers pay a fair price for their coverage and nothing more. For plan year 2015, Consumers Union observed the potential for carriers to disguise rate increases experienced by individual consumers by counterbalancing increases with decreases in other plans[2] under the same product. We wholeheartedly agree with HHS' statement that consumers are affected by rate increases at the plan level, not the product level. It is therefore imperative that unjustifiably priced plans are not lumped together with more favorable plans into a single "product" that escapes rigorous review.

In response to HHS' inquiry, although it is likely this proposal will increase the burden on reviewing entities—because more plans may hit the threshold for review (currently 10% increase) —this clarified requirement is in line with the intent of the ACA's rate review section, is protective of consumers and is therefore justified.

Taking this one step further, however, we strongly encourage HHS to reevaluate their implied decision, in this section, to keep the rate review trigger at ten percent. In many cases, for the 2015 plan year, carriers were careful to keep rate increases below the threshold. However, a 9.9% rate increase is negligibly more affordable than a 10% increase, suggesting the threshold is arbitrary. Although we appreciate that it sets a manageable workload for reviewers, and at least captures the worst offenders, we encourage HHS to consider lowering the bar to a threshold more aligned with sustainable rates of health spending growth.

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[2] Within this comment letter, Consumers Union will use the definition of "plan" as proposed by this NPRM: the pairing of the health insurance coverage benefits under the product with a metal tier level. The product comprises all plans offered within the product, and the combination of all plans offered within a product constitutes the total service area of the product.

Average Annual Per Capita Growth	1990-2012	2000-2012
GDP	3.7%	3.7%
Health Spending	5.8%	5.6%

Source: National Health Expenditures from CMS. Per capita health spending is the sum of out-of-pocket spending and health insurance expenditures.

As the table above shows, long term annual growth in per capita health spending is well below ten percent and general economic growth is far below that. It's time to lower the review threshold and increase our understanding of factors that drive premiums higher than aggregate spending.

§154.220 Timing of providing the rate filing justification

The autonomy reserved for states deemed by HHS to have Effective Rate Review reveals a patchwork of processes nationwide. Because of the varying levels of transparency among the states, consumers are often in the dark as to when RFJs would be available for review, if they would be available at all. We applaud this proposal's intent to improve predictability and transparency across the country. We also agree that, if enacted, it would establish a more meaningful opportunity for consumers and other stakeholders to comment on proposed rate increases before those increases are finalized. However, we caution that this advancement will only be realized if states make the RFJs publicly available with adequate time, for example within 60 days, for consumers and regulators to review and to submit comments.

We support the clause that gives states flexibility to impose earlier rate filing deadlines to meet their specific State needs. CMS requests comment on specifying in future guidance a deadline for carriers to complete and submit their RFJs for proposed rate increases in the individual and small group markets for both QHPs and non-QHPs. We support setting a specific deadline for RFJs both on and off the exchange. Having a deadline would facilitate the public release of rate filing information. In the past, CMS has cited the information imbalance between on- and off-market products as a reason to hold RFJs secret, citing market competition concerns. By setting a final date upon which all RFJs must be filed, CMS and the states can then publicly release information without furthering or harming carriers' competitive position in the market.

§154.301 CMS's determination of Effective Rate Review Programs

§154.301(b) We support amending this section to specify the minimum time frame and manner for a state with an Effective Rate Review Program to provide public access to information. There is currently too much variation in timing and quality of public access to information among the states. We hope this amendment will address that problem by setting a reasonable minimum that states may exceed in terms of quality and timing. In specifying the minimum time frame and manner states must make information available to the public, we would like to see a standard that calls for providing a meaningful opportunity for public review of the complete filing at least 60 days before rates are approved or before rates go into effect, whichever is earlier. To avoid

undermining states that already have strong rate review rules, HHS should set a federal floor with permission for states to build upon that foundation.

§154.301(b)(1)(i) We strongly support requiring each state to provide access from its website to the information contained in Parts I, II, and III of the RFJ and to have a mechanism for receiving public comments on those proposed rate increases. Currently, many states fail to provide timely and adequate access to rate filings prior to their effective date. In most states, consumers do not have a meaningful opportunity to comment on proposed rate increases. The barriers include:

- Too little public notice of the process and potential role for consumers
- Difficulty finding the filing and accessing a place to comment.
- Too high a cost to gain access to the filing
- Too little of the filing is made public -- all three parts of the filing need to be made public in order to understand and comment on the justification.
- Absence of help understanding the filing.
- Little clarity on what happens to comments once submitted.

Therefore, we urge HHS to set clear expectations for the minimum breadth of information made available to the public, including:

- The complete filing – Parts I, II and III must be made available.
- State website must clearly specify how consumers can comment on the filing, how to obtain the filing, all relevant deadlines and where to go for help.
- Consumers currently enrolled in the plan must receive a notice from the issuer about the proposed increase (or decrease) at the time of filing and any plan design changes, along with instructions on how to comment.
- The state website must make it clear what happens to comments that have been filed, the resolution of the requested rate increase and how to request additional information or file a complaint.

We propose that states whose standard for public access to the complete RFJ filing fails to meet the above criteria should receive additional evaluation by CMS before being designated or allowed to continue their designation as having "effective rate review "status. That additional scrutiny would consider whether filings are available via an alternative means to posting, whether and the degree to which the state affords consumers an opportunity to engage in the review and commenting process, and the overall transparency of the rate review process in the state.

We support having the Secretary set a date for posting RFJ information, with the ability for states to post earlier. We caution HHS about the importance of setting this date early enough that the public can use the materials as part of a rigorous rate review. Therefore, unless rate review nationwide is streamlined via the proposal in §154.220, the deadline the Secretary sets should be a certain number of days into each states' rate review period, rather than a specific calendar date that may be too late in some states for meaningful rate review and too early in other states to be feasible. We desire a standard that calls for providing a meaningful opportunity for public review of the complete filing (as described above) at least 60 days before rates are approved or before rates go into effect, whichever is earlier.

We caution against the suggested future guidance of a deadline of 10 business days after receipt of all RFJs in the relevant State market for information to be posted about proposed rate increases that are subject to review. We have a number of concerns, including that it is meaningless for rates that are already subject to review and may hinder states' ability to re-evaluate whether to review an RFJ after the 10 day period. Further, having states publicly list which RFJs are subject to review—and impliedly which are not subject to review—may suppress consumers' interest or willingness to comment on rate filings that will impact them, quieting a potentially useful source of information for state insurance regulators.

Finally, we oppose basing the requirement on States to post information contained in Parts I, II, and III of the RFJs on what CMS makes available on its web site. While CMS must continue to act in lieu of states that are not designated as having "Effective Rate Review", CMS has historically been slow to make any or all of the RFJs available to the public. Indeed in 2014, for the 2015 plan year, CMS failed to make RFJ data available until the day prior to Open Enrollment, and still has not released the actuarial memoranda contained in Part III of the filings. For much of this hidden information, CMS cites potential trade secret protection requests by carriers; to date CMS has not disclosed receiving any such request. Experience in states that reject trade secret protection for rate filings (CA and NY, for example) demonstrates that consumers are better served by lifting the veil of secrecy over the RFJs. Using CMS's example as a guide for making materials available to the public would handicap this proposed rule. We therefore recommend specific criteria for public access to the entire RFJ—including Parts I, II, and III—regardless of the content of CMS' website.

§154.301(b)(1)(ii) As in the preceding section, we strongly support requiring each state to provide meaningful public access from its website to the information contained in Parts I, II, and III of the RFJ. However, for the same reasons stated, above, because of CMS's failure to post all three Parts of the RFJs during rate review, or even prior to open enrollment, we oppose using CMS's website as a guide for what information the States should make available online. It is imperative that all three parts be posted; CMS's failure to do so should not provide a loophole for states to similarly let down the public. For the same reason, we urge HHS to remove the option of providing CMS's web address in lieu of posting information on a state-run site.

Furthermore, although we support setting a deadline for states to make RFJs and final rate increases publicly available, we strongly oppose setting that date as "no later than the first day of the annual open enrollment period". Having rate information available in advance of open enrollment is necessary for enrollment assisters to do their jobs well. Holding that information in confidence until the eleventh hour not only hinders Assisters, and consumers researching on their own, but serves no legitimate purpose. We, therefore, recommend that this deadline be changed to require that the final rate increases (and decreases) be made available to the public within 5 business days of rate finalization or 15 days prior to the commencement of open enrollment, whichever is earlier.

§154.301(b)(2) There is a lot of value to both HHS and the consumer community for knowing in advance when RFJs and final rate information will be released to the public. Because carriers have a deadline by which time they must submit RFJs, there is predictability in when that information will be available to states; we therefore support the requirement that States notify

HHS 30-days in advance of posting the RFJs. We suggest allowing States to notify CMS of their intended timeline before they actually receive or review any filings. For example, a state that knows in April that they are scheduled to post RFJs on June 1 should be permitted to file their advance notice in April rather than waiting to receive the actual materials and then have to wait thirty days to post.

However, we understand that it may be difficult for states to accurately predict when rates will be finalized in their states, and therefore difficult to precisely notify HHS 30-days in advance of posting without slowing down the release of information. We therefore recommend allowing States to submit an estimate of a one or two week period within which final rates will be available. Finally, because we oppose setting the deadline to release final rates as "no later than the first day of the annual open enrollment period", HHS should revise the language in this sub-section to only require notice if a state intends to make final rates available more-than 15 days prior to the commencement of open enrollment (based our recommended deadline, above).

We do not believe that a State's failure to notify HHS in advance of an early public posting of RFJs and final rates should bar the state from Effective Rate Review status, especially given that consumers may benefit from early release of RFJs and final rate information. Rather, early posting without sufficient notification to CMS should be considered in the context of the state's overall rate review program.

Finally, if this part of the proposed rule is enacted, we recommend that HHS clearly detail how CMS will use the information and make it available to the public. For example, we strongly encourage CMS to publicly list on its own website when materials from each state will be available. Doing so will greatly serve the interest of consumers and consumer advocates who in 2014 were frequently unable to know in advance when rate review periods would start and when final rates would be available across the country. We recommend a public-facing, web-based table that lists for each state: the non-group and small group dates for public posting of justification along with web links to filings and information on how to comment. To ensure this requirement serves its intended purpose, CMS must keep the information current, updating it when new information becomes available or at least every three days in the months leading up to rate review in all jurisdictions and continuing until the annual open enrollment period.

§155.222 Standards for HHS approved vendors of Federally-facilitated exchange training for agents and brokers

Consumers Union lauds HHS for requiring vendors to get approval from HHS before using their information and training programs for agents and brokers providing assistance to the individual and SHOP Marketplaces. We have been concerned that until now, the training and certification programs for agents and brokers were not standardized or reviewed in any way by HHS. Given that the health insurance market has changed considerably – and that applicants seeking assistance from brokers and agents may be eligible for insurance affordability programs (not just commercial ones) – it is essential that broker and agent trainings are robust and cover the multitude of programs and situations that consumers might be eligible for. We are also happy to see that HHS is instituting an auditing process to ensure vendors are meeting the standards, ensuring that vendors that do not meet standards lose their official recognition.

§155.355 Annual eligibility redetermination.

In the preamble, HHS seeks comments regarding contemplated new hierarchies of default plan selection for re-enrollment, to be chosen by the consumer at the time of initial enrollment and/or special enrollment, for 2017. HHS also seeks comments on how to ensure that consumers understand the risks of defaulting into a plan, rather than making a pro-active selection.

Consumers Union celebrates the fact that millions of people now have comprehensive coverage through the FFM and state-based Marketplaces. We do not want them to lose this vital benefit through inertia or inadvertence, by missing re-enrollment deadlines or not receiving a notice. But we contend that the key to consumer-friendly re-enrollment rules—whether pro-active or by default—is ensuring that consumers are grounded in factual information about the implications of their plan selection, as discussed more fully below.

While the preamble proposal aims to give consumers a choice of default hierarchies, it may be an empty choice. To decide a year in advance whether you want to be defaulted into staying with the current plan or shifted to the plan with the least expensive premium (if the current plan does not meet that definition) risks requiring consumers to act on unknowable information—e.g. what the offered plan designs and premiums are likely to be the following year, what their eligibility might be for APTCs or other cost-sharing reductions, and whether any of their current providers will participate in that future plan option. All these variables make choosing the "right" default option impossible. We do not see a way to effectively overcome the information deficit.

Moreover, consumers already face significant difficulty evaluating the multiple variables involved in shopping for health insurance plans that are currently being offered. Adding another level of complexity that asks consumers to decide—in most cases 12 months ahead of time—how they want auto-enrollment to proceed, will further confuse an already challenging process. One result could be paralysis and avoidance of making any decision on default options—which would require HHS to have its own default.

We contend that a preferred approach would be to require much improved comparative information from the FFM and state-based Marketplaces to consumers at the time of renewal. If their current plan is experiencing significant changes in premiums, cost-sharing, formulary, other covered services or the provider network, the Marketplace notice should say so.

If the FFM and state-based Marketplaces provide consumers with sufficient information that allows them to shop and decide whether or not to affirmatively switch plans, we see the benefit in avoiding coverage gaps for consumers by providing a default at re-enrollment. Remaining in the same plan, which is the norm in the employer benefits context, relies on familiarity with the product which the consumer shopped for, compared and chose at initial application. Even if the plan is not perfect from the consumer's perspective, many may prefer the "devil they know" to the one they do not.

We do not recommend default into the lowest cost plan, however. This proposed option may yield significant, multiple, unwelcome surprises. First, it could potentially shift consumers to an

entirely different type of product—e.g. a PPO when they are accustomed to and originally chose an HMO with an integrated network. This change of plan type could have significance for them even if the PPO is at the same metal level. The new "lowest cost plan" will not necessarily be one in which their long-term provider is included in-network or in which their regular medications are included on the formulary. While we agree that consumers care deeply about premium cost, they also care about their providers, plan customer service, plan type (PPO,EPO, HMO), and cost-sharing when using the plan. In many instances, consumers choose plans because of "brand loyalty" or "brand aversion" based on their personal experience. Furthermore, the label "lowest cost plan" may be misleading, since the plan may not end up with the lowest *total costs* for the particular consumer (especially taking into account the consumer's likely usage level and deductibles, co-insurance, and co-payments).

Consumers Union does not see a way to effectively educate consumers sufficiently to overcome these complexities and thus finds that the downsides of allowing consumers to default into the "lowest cost plan" outweigh the potential benefits.

The preamble asks for comment on whether the "lowest cost plan" default option would drive issuers to be more price-competitive in order to attract or keep enrollees. We caution against that as an independent criteria for evaluation as we don't want insurers to compete on premium alone, but rather on overall value (affordable cost-sharing and high value providers in the network). Further, we believe that there are better ways to rein in premiums, including standardizing benefits, undertaking rigorous rate review, early and complete transparency of all rate filing information (well before open enrollment), and best practice plan comparisons on the FFM and state-based Marketplace websites.

Rather than offering advance default enrollment options, the FFM and state-based Marketplaces should provide clear and conspicuous information on the website and in all insurer and Marketplace communications to enrollees that emphasize the importance of proactively shopping at renewal time *and* robust, thorough and informative notices that lay out for enrollees—at the key renewal and decision points— the facts relevant to the particular consumer and implications of being default re-enrolled into *any* plan. California, a state in which Consumers Union is intensively involved with the Marketplace, has taken this course, providing enrollees in its QHPs with customized notices at renewal. If the consumer has provided updated income information (including permission to confirm income through the federal data services hub), the renewal notice from Covered California indicates the new premium and the prior and projected APTC amount, etc.

While the FFM's default enrollment for 2015 into the chosen 2014 plan has not been optimal, we are not convinced that it is a problem with default enrollment, so much as a problem with missing information in the FFM's renewal notice to consumers.[3] It is our understanding that currently the FFM does not provide consumers a notice that displays 2015 premium charges, any changes in the enrollees' APTCs, changes to the benchmark plan, or changes to the 2014 plan's benefit design. Without adequate notice from the FFM of the implications of the default

[3] We recognize that the issuers are required to provide notices with premium and APTC information to consumers, but believe the timing of such notices and delivery by the plan may not foster the maximum awareness and choice by consumers.

enrollment into the same plan, it is possible that people are not acting because of insufficient information that highlights the implications of defaulting to the current plan.

In summary, there is no reason to assume that defaulting into the lowest cost plan will be preferable for consumers over automatically renewing into their current plan, given the potential for differing provider networks, formularies, and total costs (when deductibles, co-insurance, etc. are taken into account) without a full understanding of those implications at the point of decision. Moreover, offering enrollees the option to select an alternative default enrollment hierarchy at the initial enrollment may be needlessly confusing and possibly harmful to consumers who select that option, not fully understanding what it means, and resulting in a suboptimal lower-premium plan when they are defaulted many months later.

For these reasons, we urge HHS not to give consumers the misleading option to default into the "lowest-cost" plan. Instead, we urge you to retain the default into the current plan, *but* also to ensure that the FFM and state-based Marketplaces provide renewal notices with transparent, up-to-date, and robust information about changes in premiums, benchmark plans, APTCs and benefit design, so that consumers are fully informed about changes to their current plan. With clear and accurate information in the renewal notice—combined with consistent, conspicuous messaging about the importance of "shopping" at renewal time—consumers will understand more fully the consequences of staying in their current plans and may be encouraged to return to the FFM to shop for plans before default re-enrollment. Without more information about alternatives, both the FFM and state-based Marketplaces should continue to default consumer's into their current plan—of course, retaining the right for consumers to proactively shop, compare and choose a plan for the coming year rather than accept default and ensuring clear, frequent messaging on notices and websites encouraging them to do so.

We also suggest that HHS undertake surveying of current FFM enrollees of their renewal experiences, analysis and public reporting of the 2014 renewal selection or default results, and consumer testing going forward to understand consumers' preferences for default options and to determine the best way to communicate plan options to consumers.

§155.410. Initial and regular open enrollment periods.

Consumers Union understands CMS' desire to ease system operations by not straddling enrollment over two calendar years (Nov. to Feb.), but we have concerns about the abbreviated and earlier open enrollment period proposed for January 2016 and beyond (i.e. October 1 to December 15). The preamble states that part of the rationale for this shortened period is that consumers are now familiar with Exchanges and thus will have sufficient time to choose or change plans. However, we question how familiar consumers really are given the newness of implementation and complications of the first open enrollment, roll-out period. Moreover, system slow-downs and call center overload are causing consumer delays in reaching Exchanges to apply and choose plans for 2015, even in high-functioning Exchanges and with the current, longer open enrollment period. We wonder whether a phased in approach might be wiser, staying with three full months for 2016 enrollment.

We are especially concerned about the logistics of the proposed time frame for enrollees who are defaulted into a plan (under current or proposed default rules) and who do not understand that a default assignment has been made or the implications of this default assignment until the default plan takes effect (starting January 1). If open enrollment is closed before the enrollee has a chance to opt out of the default plan and to choose a new one, the consequences may be serious financially or in terms of lack of access to providers, needed medications, or services. At the least, we urge HHS not to move the end date any earlier in December than proposed, and to create a special enrollment period for auto-enrolled consumers who wish to switch to a different QHP (see below comment on **§**155.420).

§155.420 Special enrollment periods.

We support the proposal for a special enrollment category for individuals who experience a death in their family or divorce outside the regular, open enrollment period. These events can deprive people of health insurance unexpectedly and, like births and marriages, which are already covered by SEPs, are major life changes that often result in reduced income and increased likelihood of eligibility for APTCs. We are concerned, however, that the special enrollment period is limited to individuals already enrolled in a QHP. We urge HHS to create a broader special enrollment trigger for people who experience a change in household size or income that makes them eligible for APTCs.

When a divorce or death occurs, low- and moderate-income individuals would be prevented from accessing important financial assistance to help them purchase insurance. If a family chose to purchase non-group coverage outside the Marketplace and then the death of the breadwinner occurred after open enrollment, the surviving spouse and children could easily be newly eligible for APTCs, but unable to access them until the next open enrollment. We strongly urge HHS to allow special enrollment for death and divorce—and any change in tax household composition or change in income that would make individuals eligible for APTCs—regardless of whether the individuals are currently enrolled in a QHP. This sort of broadened category we suggest would also make it easier for consumers and assisters to comprehend the circumstances under which SEPs are available since this more general category could supplant several fragmented ones.

The NPRM asks whether any additional special enrollment periods are appropriate. We think the following are warranted new special enrollment categories:

- Individual was default-enrolled and wants to opt out of the default assignment. For the reasons described above in relation to §155.410, if the open enrollment period is moved up in time and the length of the period shortened, we urge that consumers who were auto-enrolled have 30 days from the effective date of coverage to switch plans.
- Individual relied on materially inaccurate provider directory information when choosing a Marketplace plan. While we appreciate that CMS is taking steps elsewhere in this proposed rule to help make provider directories more accurate and up-to-date, consumers who make an effort to choose the right plan based on the information they reviewed in the directory should not be trapped in that plan if it turns out that their doctor, hospital, or other health care provider is not part of their plan's network or their drug is not on the plan formulary.

- Individual with an acute or chronic disease or condition and in the midst of active treatment lost access to their treating provider due to a mid-year change in their plan's network. Patients undergoing treatment for an acute or chronic disease who chose a plan with the expectation that their doctors or other needed health care providers are in-network can find themselves in a dilemma if their provider leaves their plan's network or is moved to a higher-cost provider tier midway through the plan year. These patients are forced to choose between continuing to see their trusted provider but at significantly higher out-of-pocket costs or switching to a provider who is not familiar with them or their condition. While we recognize that some insurers may provide "continuity of care" coverage, such coverage is not guaranteed and the length of such coverage is often inadequate.
- Individual lost affordable access to a needed prescription drug due to a mid-year change in their plan's formulary. Likewise, patients who choose a plan based on its coverage for a particular necessary medication are caught in an untenable situation if the drug is dropped from the plan's formulary or moved to a higher cost-sharing tier. Such changes can make the medicine unaffordable. While we recognize that some patients may be able to continue to access their medication through the plan's exceptions process, providing a special enrollment trigger provides another remedy, particularly important if their exception request is denied.

§156.122 Prescription drug benefits

Consumers Union applauds the proposed regulations that provide a more robust standard for enrollees to access non-formulary drugs, and an exceptions, appeals and expedited appeals process when such access is denied, including an independent medical review.

In addition, we strongly support the inclusion in (d) to require that prescription drug formularies be made publicly available to prospective enrollees, enrollees, regulators and others. For many people shopping for insurance, whether or not a specific medication is covered under a plan's formulary is one of the most important considerations. HHS should require that the formulary lists are not only accessible to the general public, but also updated regularly. Moreover, the formularies need to be clear and transparent about tiering, including not only cost information about each tier level, but also the criteria by which the tiers are organized. Clear information about tiering is especially important given that there is no one standard or uniform definition used today to delineate "specialty" drugs.

We also believe that HHS should establish a uniform standard for "specialty" drugs that is narrow and is applied consistently across all issuers. It should not be left up to each individual issuer to decide the criteria of what makes a drug "specialty. As we have seen on the market today, they often make those determinations solely on cost, which often has discriminatory impacts in discouraging people with certain conditions from enrolling. We believe that "specialty" might encompass those drugs that require close clinical monitoring and management or that frequently require special handling. The criteria should not be simply those drugs that are high cost. Higher cost Tier 3 and Tier 4 drugs should be limited to those that have therapeutically equivalent drugs available in lower cost tiers. Not only should HHS supply a

definition, but they should also monitor to ensure that the specialty drug tier offered by issuers conforms to the HHS definition.

§156.230 Network adequacy standards

Network adequacy remains a huge concern for consumers. In the first year of Exchange enrollment, consumers signed up for coverage relying on information from provider directories and too often found out after the fact that their providers were not in the network after all. We support efforts to strengthen the standards issuers must meet for their networks to be deemed "adequate." We are disappointed that the draft regulations do not go far in making network adequacy more meaningful, given the many problems with networks that have been identified over the past year.

§156.230(a) network adequacy general requirement
Of the revisions that are proposed, Consumers Union supports the revised regulation that makes clear that the adequacy of a provider network is judged only on the providers that participate in the network; network adequacy standards cannot be met through counting out-of-network providers.[4]

Consumers Union also appreciates the strong language in the preamble that encourages issuers to offer new enrollees transitional care at in-network prices for an ongoing course of treatment. A particular specialist may be very important for a consumer with a serious medical condition who has been treated by him or her for some period of time. And transfers of medical records to, and appointment scheduling with, a new in-network provider may take time. The scope of inaccuracies in provider directories and lack of comprehensive, integrated directories showing which plans specific providers are covered in as in-network providers makes it very difficult for consumers to ascertain this critical information within a short timeframe. We urge CMS to create continuity standards that set a floor to ensure no disruption in treatment, allowing states that wish to be more protective of consumers' leeway to do so. We note that continuity of care provisions need not only ensure that the consumer can access the needed care at in-network cost-sharing, but also protect consumers from balance billing by providers.

§156.230(b)

Consumers Union strongly supports the strengthened provisions on access to issuers' provider directories. Consumers continue to face challenges navigating and using provider directories online, assessing the accuracy of provider directories, comparing directories across plans, and understanding how to proceed when a plan they picked for a certain provider does not renew a contract with that provider in the middle of the plan year. We believe that the provisions proposed in §156.230(b), with strengthening, are essential for ensuring that consumers have adequate information throughout the coverage year, both at open enrollment and during special enrollment.

In particular, we agree with HHS that provider directories should be accessible to enrollees, prospective enrollees, and the general public online and, upon request, via paper. The directories

[4] Federal Register, Vol 79, No. 228, page 70726 (November 26, 2014).

must be kept up-to-date, they must be accurate, and they must be complete. Equally important, they must be updated in a timely fashion and provide important and detailed information about providers participating in the network.

Consumers Union believes that the proposed regulations should go further in making provider directories more meaningful for consumers. In addition to the information about which providers are accepting new patients and specialty, medical group, and institutional affiliations (e.g. hospital privileges), they should be required to include better information about access to services for limited English proficient and disabled populations.

> **CU Recommendation**: Revise §156.230(b)(2), to state: (2) "A QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any independent practice association (IPA) or institutional affiliations. In addition, the directory must identify languages spoken by the provider and whether the provider office is accessible to people with disabilities. The information should be displayed in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM."

We support the provision that defines that the directory is "easily accessible" by being on the issuer's public website with a clearly identifiable link. We especially agree with the requirement that when there are multiple provider networks, the website and links to the directory must be clear in indicating which network is associated with a particular plan. In our research of issuer directories, this clarity has been lacking.

In addition, the preamble suggests that provider directories should be updated at least once per month. We applaud HHS for establishing a standard for regular updating. We believe, however, that issuers should update provider directories more frequently than the suggested once per month. Issuers keep extremely current about which providers are in their networks in relation to their claims payments, and we see no reason why, in this electronic era, that information cannot be shared with consumers in an equally timely way by updating their web sites in an ongoing manner, every week or more frequently.

The preamble also suggests that HHS is considering requiring that publicly accessible provider directories be in a machine-readable file and format. We strongly support the preamble language and would urge HHS to incorporate this into an actual regulatory requirement. An integrated provider directory available on an Exchange's website, for example, will best allow consumers to shop for and compare plans. The requirement that all directories be in a machine-readable file will ensure that consumers have access to integrated provider directories at the earliest date possible.

> **CU Recommendation**: Add provision to §156.230(b)(2), which states: "(ii) it is provided to the Exchange in a machine-readable file and format specified by HHS and/or a state-based Exchange."

Consumers Union has developed a set of consumer protection principles for provider directories.[5] We suggest to HHS that the additional protections embodied in this document could be incorporated into 156.230(b).

§156.235(a)(2)(i) Essential community providers

Consumers Union supports HHS' proposal to require QHPs to include at least a minimum percentage of ECPs in their provider networks for the FFM. For 2015, CMS determined that the minimum percentage would be 30%. We suggest that the standard minimum percentage also be applied to state-based Marketplaces, as a floor, allowing state-based Marketplaces to set higher standards.

§156.250 Meaningful access to QHP information

Consumers Union strongly supports expanding meaningful access to QHP information beyond simply the application and notices to include all information that is critical for obtaining health insurance coverage or access to health care services through a QHP. The proposed direct cross-reference to §155.205(c) ensures that the requirements are clear: that such materials must be in plain language and accessible and timely to those with disabilities and individuals with limited English proficiency. It is only when consumers have meaningful access to information that they can shop for and use their health insurance wisely, and as the preamble recognizes, individuals need to be apprised of the availability of accessibility services such as translations.
In response to the request in the preamble for comments on whether critical documents should be further defined, we urge further strengthening of the language in the regulation to make explicit the types of documents that fall under the new standard:

> **CU Recommendation**: The provision should be revised to state: "A QHP issuer must provide all information that is critical for obtaining health insurance coverage or access to health care services through the QHP, including applications; consent, grievance, appeal and complaint forms; notices pertaining to the denial, reduction, modification or termination of services, benefits, non-payment, or coverage; a plan's Summary of Benefits and Coverage, explanation of benefits, or similar claim processing information; QHP ratings information; rebate notices; correspondence containing information about eligibility and participation criteria; notices advising individuals of the availability of free language assistance; and letters or notices that require a signature or response, to qualified individuals, applicants, qualified employers, qualified employees, and enrollees in accordance with the standards described in §155.205(c) of this subchapter. Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the issuer is required by law or regulation to provide the document to a qualified individual, applicant, qualified employer, qualified employee, or enrollee."

[5] "Making Provider Directories Meaningful to Consumers," Consumers Union, December 2014. Available at http://consumersunion.org/wp-content/uploads/2014/12/Provider_Directories_principles_1214.pdf

§156.420(h) Plan variation and 156.425(c)

Consumers Union is a strong proponent of the Summary of Benefits and Coverage form, which serves to help people understand the coverage and costs of each plan that they are shopping for (and using). Consumers Union applauds the new provisions, 156.420(h) and 156.425(c) that require that issuers create and make publicly available SBCs for the cost-sharing reduction variations for Silver plans. Requiring SBCs for all plans, including Silver 73, Silver 87 and Silver 94 plans, will enhance a consumer's shopping experience and help ensure that those eligible for cost-sharing reductions understand the benefits of choosing a Silver level plan. We believe a comprehensive and accurate SBC for cost-sharing reduction Silver plans will help consumers better understand the benefits of choosing a Silver plan.

On behalf of Consumers Union, we thank you for the opportunity to comment on this important rule making and would be happy to answer any questions.

Sincerely,

DeAnn Friedholm
Director
Health Care Reform