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December 21, 2015

Secretary Sylvia Mathews Burwell
Department of Health and Human Services
Attention: CMS-9937-P
P.O. Box 8012
Baltimore, Maryland 21244-1850

Submitted via www.regulations.gov

Re: **CMS-9937-P: Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2017**

Dear Secretary Burwell,

Consumers Union, the policy and advocacy division of Consumer Reports,[1] commends HHS and its agency partners for crafting strong provisions that strive to fulfill the promise of the Affordable Care Act (ACA) and promote strong consumer protections in the Notice of Benefit and Payment Parameters for 2017.

We appreciate the opportunity to comment. To that end, we dedicate a substantial portion of our comments to the sections regarding standardization of cost-sharing in the individual market and related provisions, network adequacy, and web-based entities. We address these topics first, out of chronological order. More abbreviated comments on other sections are listed in chronological order after these more detailed sets of comments.

[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 1 million online activists to change legislation and the marketplace in favor of the consumer interest.

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§156.20 Standardized cost-sharing benefit designs

The Preamble allocates several pages to discussion of standardized options as a means to improve the stability of the Exchanges and consumers' ability to make informed choices, with a brief definition proposed for new §156.20. We strongly support standardized cost-sharing designs as described more fully below and offer specific comments. Our support stems from our organization's foundational belief that the ability to compare health insurance products on an apples-to-apples basis is essential for sound consumer decisionmaking. For decades, consumers in our country have been confronted with a bewildering array of benefit designs that, in the guise of affording options for every possible preference, have obfuscated and made impossible the determination of the true value of plans. The Affordable Care Act promised to change that, and standardizing plans is an essential step in that direction.

Consumer testing has shown that standardizing benefit designs within actuarial value tiers provides great benefit to consumers. While several states have enacted standard designs[2], here we focus on groundbreaking work at Covered California that has zeroed in on the particulars of standardized benefit design. That work resulted in extremely positive outcomes for consumers and for Exchange enrollment, as described more fully below. Consumers Union is more persuaded than ever that a similar approach is the right course for the FFEs and other state-based Exchanges, as well as their enrollees.

The California experience

Covered California exercised its option to pursue consumer-friendly, standardized cost-sharing benefit designs from the outset in order to enhance the consumer experience of care, improve the health of populations, and reduce the cost of health care overall. From 2012 to the present, Consumers Union participated in an active work group with other stakeholders, examining and proposing refinements to the standard benefit designs. In refining the original designs, our goals for standardized cost-sharing included:

- Simplicity—aiding consumer understanding and the ability to compare and contrast coverage options;
- Incentivizing the best care—for example, fostering the use of primary care through lower cost-sharing or exempting specific services from application of the deductible;
- Reducing the use of co-insurance—this unknowable dollar amount makes it impossible to estimate out-of-pocket costs, therefore creating confusion when consumers shop for and use coverage;

Throughout the work, it became clear that, limited by the actuarial value calculator requirements, there are often tensions among the above stated goals. For example, eliminating co-insurance

[2] Realizing Health Reform's Potential What States Are Doing to Simplify Health Plan Choice in the Insurance Marketplaces, the Commonwealth Fund, December 2013. Available at http://www.commonwealthfund.org/~/media/Files/Publications/Issue Brief/2013/Dec/1720_Monahan_what_states_are_doing_simplify_rb.pdf

altogether came at a high cost to affordability of co-pays. Likewise, consistency regarding when the deductible applies across metal tiers' played out differently depending on actuarial values.

Working through these goals and tensions in an iterative process since 2012 has gotten Covered California to a favorable position for the 2016 plan year. Standardized cost-sharing in California, twinned with selective purchasing (See comment on §155.1000 below), has resulted in a reasonable overall premium trend (4% average increase for 2015) and designs that allow for easier, at-a-glance comparisons of offerings by price, provider network, and quality.[3]

The improved designs for 2016, and those planned for 2017, address several of the topics HHS raises in the preamble. For example, for 2016[4] Covered California eliminated co-insurance for all but certain outpatient services; removed deductibles for any outpatient services in silver, gold and platinum tiers; and exempted from the deductible in the Bronze plan three office visits (primary care or specialist) and lab costs, so that those who purchase this low actuarial value product get some benefit from it without having to reach the very high deductible.

Overall comment on the NPRM approach to standardization of cost-sharing

The NPRM states HHS' intention to make standardized cost-sharing designs an option for plans and to encourage issuers to offer at least one such standard plan at the Silver level (and associated cost-sharing reduction plans). Consumers Union understands the incremental approach, but in light of the tremendous difficulty consumers have in making informed plan decisions without standardized designs, we urge HHS to move expeditiously to **make standardized cost-sharing plans mandatory for all issuers to be certified as Qualified Health Plans** (QHPs). Moreover, we urge you to **require standardized benefit designs not for just the Silver tier, the most popular with consumers, but for all five tiers (including catastrophic)**.

Furthermore, Consumers Union urges HHS to **reconsider allowing QHPs unfettered flexibility to continue to offer non-standardized options**. Rather, we recommend HHS ***require exclusive use* of standardized cost-sharing plans by QHPs**, if not for 2017, then for future years. It is well settled in the research literature that too much choice in health coverage products adds complexity and confusion beyond the cognitive ability of consumers to make well-reasoned decisions.[5] Assessing trade-offs among scores of non-standard cost features is an impossibly complex task for consumers, requiring numeracy skills lacking amongst the American public. Such an assessment requires the ability to combine complex concepts—such as applying deductibles, considering unknowable co-insurance amounts, and whether co-pays apply to

[3] See Consumer Reports' praise for standardized cost-sharing benefit designs offered by Covered California as a boon to transparency in 2015 Naughty and Nice List: Consumer Reports reveals its annual review of company policies and practices. Available at: http://www.consumerreports.org/consumer-protection/naughty-and-nice-2015

[4] Covered California Standard Benefit Designs and Medical Cost Shares.. Available at http://www.coveredca.com/PDFs/2016-Health-Benefits-table.pdf

[5] Quincy, L. and Silas, J. "The Evidence is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumers Decision Making." November 2012. Available at http://consumersunion.org/pdf/Too_Much_Choice_Nov_2012.pdf

deductibles or not—to roll up into a final assessment. In short, this assessment is impossible among non-standard cost-sharing designs. And the implications are profound for consumers: frustration and fear in investing that may cause consumers to not enroll; under-insurance, by making the wrong choice; and potential disillusionment with the Affordable Care Act.[6]

On the other hand, limiting the number of products and making them all standardized would allow for simplified displays and enable valid comparisons based on premiums, provider networks, and quality—so consumers are able to truly assess the value of product options rather than making a shot in the dark. This was what consumers most hoped the Affordable Care Act would provide for them. Research suggests that 6-9 offerings are the number above which confusion sets in and blurs sound decision making.[7]

HHS suggests that allowing issuers to offer multiple plans through an FFE for each standardized option within a service area would be permitted only if the plans were "meaningfully different," thus providing a check on an unbridled number of offerings . **Consumers Union believes that offering multiple standardized plans is not ideal, but agrees that if allowed it should only be if they are truly different in a significant way.** In this regard, we note that Covered California in 2014 and 2015 offered both a Silver HMO and a Silver PPO standard plan to allow consumer choice. However, given actuarial constraints, there was actually little difference between the two offerings: each had similar co-pay and coinsurance features. Given the little difference, Covered California no longer allows both plans to be offered for 2016.[8]

We note for future purposes that if there is an appetite for new features, such as value-based benefit designs, the evidence of their benefit could be evaluated and, if found worthwhile, incorporated in the standard designs in future years. That is, **any such alternative designs could be required of all plans in a consistent way, if found to have value.** Thus, the possibility of design adjustments across all plans based on new ideas should not be viewed as grounds for not doing standardized benefit designs for 2017.

Prioritized, differentiated display of standardized plans is critical

Even if not all products have standardized cost-sharing, we urge HHS to require prominent display of standardized plans to ensure they appear first and separated out from the non-standard plans. Consumers Union previously reported on the critical importance of display "sort order" and web choice architecture.[9] Our research findings highlighted the critical importance of the initial set of options displayed. The default display, for example, radically affects consumers' shopping experiences: once they see the default, it becomes the anchor or baseline for the rest of

[6] Quincy, L. "What's behind the Door: Consumer Difficulties Selecting Health Plans," January 2012. Available at http://consumersunion.org/wp-content/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf
[7] Evidence is Clear, *Ibid*.
[8] Covered California Open Enrollment 2013-2014: Lessons Learned. March 31, 2014. Available at https://www.coveredca.com/PDFs/10-14-2014-Lessons-Learned-final.pdf
[9] Kleiman Associates and Consumers Union, "Choice Architecture: Design Decisions That Affect Consumers' Health plan Decisions," July 9, 2012. Available at http://consumersunion.org/wp-content/uploads/2013/02/Choice_Architecture_Report.pdf

the selection process. As our research has noted, "What consumers see first will frame their understanding of the rest of the information – in effect, creating a mental model for them."[10]

We strongly urge you to ***separate out the standardized plans and make them the first ones a consumer sees.*** While current sorting criteria may, for example, make lowest premiums appear first, we urge HHS to override that sort option by having separated standard cost-sharing plans appear before the sort by premium. This prominent display would serve two important purposes.

First, such placement will help flag the easy-to-compare plans for consumers and make the shopping process much less frustrating, enhancing the likelihood of choice of the best value plan and enrollment itself. Simply putting the label "standardized" next to a plan name on a long list of plans will not make the product stand out nor make at-a-glance comparisons easier.

Second, placing the standard plans first will incentivize issuers to offer them voluntarily to receive this favorable web "real estate" placement. Further, we strongly urge HHS to require this same placement on QHPs' and web-based entities' sites (if any), as well if a non-FFE web site is used to facilitate enrollment. **It is crucial for the credibility of offerings and consumer understanding that the same, standard displays are used regardless of the enrollment entity or venue**.

Consumers Union **applauds the stated intent to engage in consumer testing on plan comparison features and recommends consumer testing regarding descriptions of standardized designs**. We **urge HHS to conduct the testing and to incorporate a robust stakeholder process where consumer interests can be heard, rather than solely rely on testing by issuers – who may have a stronger preference for non-standardized designs.** In addition, State-based Exchanges using standard designs have valuable information for HHS on consumer experience with these products and how to describe them.

General proposed features of standardized designs

Consumers Union understands that HHS' proposed features are derived in part from the most popular designs sold in the FFE in 2015. **We urge caution in relying too heavily on popular designs, since the vast array of non-standardized plans did not make for truly informed shopping on the FFE in 2015**; thus, the choices made in 2015 may not be a valid indication of consumer cost-sharing design preferences.

However, we understand that you also referred to six states' 2014 standardized designs. The comments that follow draw on our experiences with one of those states, California, where design standards were refined over subsequent years.

A. Drug Formularies

[10] Id., p. 3.

Drug benefits and cost-sharing can be especially confusing, particularly because some plans have a separate drug deductible. Consumers Union supports your proposed standardized cost-sharing for this important benefit and **urge that you create no more than four tiers**. The current marketplace for drug cost-sharing (the NPRM cites 56% of the current 2016 FFE QHPs' offering 5 drug tiers) should not constrain or drive your effort to create the best, most affordable, understandable, standardized benefit. Slicing the drug cost-sharing into more than 4 tiers adds complexity and risks greater unfair discrimination in benefit design.

As a detail matter, you might consider giving the four drug tiers numbers (1-4) rather than names, since from our in-depth work on drug benefit design we understand that some plans may put certain generics on higher tiers. That is, the nomenclature you suggest, while intuitive, may not match up neatly with the real plan experience.

B. Provider tiers

Consumers Union **strongly supports your stated intention to allow only a single tier of in-network providers**. Having multiple tiers creates greater consumer confusion, for example, around referrals and which doctors have admitting privileges at which hospitals. In addition, the NPRM notes that tiering also affects actuarial value and thus undermines the ability to create standardized benefits. Tiering is currently used in only one QHP in California (the OPM multi-state plan) and affects a small number of enrollees. While having more than one tier may be an attractive marketing feature for brokers, it is also likely to be confusing and misleading to consumers.

C. Deductible-exempt services

Rising deductibles are a major impediment to consumers seeking the care they need and getting full value from their insurance. When actuarial value constraints require steep deductibles, exempting certain basic services from the deductible is a wise policy to incentivize use of the most needed care and to provide consumers some upfront value. Exempting office visits—primary care and specialists— from the deductible and keeping those co-pays as low as possible, incentivizes patients to get the care they need early on. Covered California has adopted that feature in the 2016 Covered plans, including allowing three pre-deductible visits to a primary care or specialist per year in Bronze level plans. **We urge you to create standard benefit designs that exempt certain basic services from the deductible.**

In addition, **we urge you to consider exempting Emergency Room visits from the deductible, as those visits may be unavoidable and medically necessary.** We should not disincentivize legitimate usage. The significant co-pays (i.e., the NPRM's stair-stepping from $100 to $400 from Silver 94 to Silver 71) should be enough to deter inappropriate usage. Exempting lab fees as well—often prescribed by doctors as part of a basic visit and not over-utilized by the patient's volition—may also be wise. Moreover, certain rehabilitative and habilitative services may be infrequently utilized, but essential to functioning and wellness.

Patients needing those services may never approach the annual maximum out-of- pocket limit, as they would for in-patient rehabilitative services, but need access prior to the deductible.

D. Co-payment vs. co-insurance

Consumers Union strongly urges HHS to further slash the use of co-insurance in your proposed 2017 standard design for all metal tiers. The dollar denominated obligations associated with co-insurance provisions are unknowable to consumers. Given the current opacity of health care costs, the use of co-insurance causes massive uncertainty for consumers and tops the list of consumer confusion about cost-sharing.[11] Eliminating, or at the least minimizing, the use of co-insurance was a primary goal for California from 2012 on; we have pared the use of co-insurance down to outpatient services, such as hospital fees and skilled nursing facilities and Tier 4 specialty drugs. We understand the concern about setting co-pays nationally, but believe reducing the use of co-insurance may be the single biggest improvement HHS could make to standardize cost-sharing to improve consumer financial security and understanding. Thus, Consumers Union's recommendation will always be to offer co-pay rather than co-insurance, where possible under actuarial value constraints.

Specific Standardized Option Designs

A. Bronze

We agree with the Preamble statement that Bronze plans resemble catastrophic plans. They may have low premiums, but offer little other than catastrophic coverage. **We support HHS' proposal for the Bronze plan to provide some upfront benefit to consumers by exempting the first 3 primary care visits and mental health/substance abuse disorder outpatient visits from the deductible.** Covered California also had this feature for 2015 and opted to open it to 3 non-preventive office visits with a primary care doctor or specialist for 2016, which may include urgent care visits or mental health/substance abuse disorders. The theory is that even some consumers without chronic conditions may unexpectedly find they need to get urgent care or see a specialist and should get some value from their premium dollars.

With regard to cost-sharing for pharmaceuticals, we note that the proposed $35 co-pay may actually exceed the over-the-counter cost of a generic drug in many cases. Even when exempted from the deductible, a relatively high generic co-pay, such as described here, may not provide consumers with great benefit. Finally, the 50% co-insurance for most other services makes this an unattractive option.

B. Silver

[11] What's Behind the Door., fn 5.

The deductibles under the proposed Silver plan are high and the drop off between Silver 71 AV to 94% AV is extremely steep. **We urge HHS to lower the deductible on your Silver and Silver 73 designs.** We appreciate the otherwise graduated differentials between the cost-sharing for benefits, a "stair step" approach Covered California also pursued. This approach is logical for consumers and aids understanding.

On exemptions from deductibles, as noted above, **we suggest exempting Emergency Room visits from the deductible, as those visits may be unavoidable and medically necessary**. We should not disincentivize the use of emergency rooms for legitimate situations; the significant co-pays should be enough to deter inappropriate usage.

Again, **Consumers Union urges reducing the use of co-insurance to the maximum extent possible in Silver plans,** as they are the primary policies for lower income consumers earning just $29,425 per year (for an individual). Similarly, the drug co-pays for preferred brand drugs and non-preferred brand drugs for Silver 71 and 73 suggested here are very high. We do, however, agree with exempting these co-pays from the deductible.

C. Specialty drugs

Specialty drugs present unique challenges and even one round of treatment for some of these high cost drugs will hit the maximum out-of-pocket (MOOP) costs in a matter of weeks. Nonetheless, overall, your proposed co-insurance for specialty drugs is extraordinarily high—for example, 40% for Silver, although not subject to deductible. By comparison, for 2016 Covered California's Silver individual plan (70.4% AV) came in at 25%, subject to a $250 pharmacy deductible. Moreover, for tiers Silver through Platinum there is a monthly out-of-pocket cap in California of $250/prescription ($500 for Bronze), to spread out the payments throughout the year to reach the $6,250 annual MOOP.[12] **Consumers Union recommends revisiting your drug benefit, especially the co-insurance amount for specialty drugs and considering a monthly cap.**

§156.230 Network adequacy standards

Consumers Union is pleased that HHS continues to strive to improve the network adequacy standards for Exchanges. Access to sufficient numbers of high quality providers is a top priority for consumers, and breadth of networks has been a concern for consumers. We support efforts to strengthen the standards issuers must meet for their networks to be deemed "adequate." We are hopeful that language in the draft regulations will go far in making network adequacy more meaningful, given the many problems with networks that continue to exist, but also believe the proposed regulations should be stronger.

[12] California Assembly Bill 339. Available at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB339

We look forward to seeing the Letter to Issuers that will provide more detail to FFE states regarding their network adequacy assessment methodology.

While we agree that states are in the best position to review and uphold network adequacy standards, **we believe it is important to establish a uniform set of minimum network adequacy expectations, solely as a floor, that all state Exchanges would have to uphold across plans, regardless of whether they participate in an FFE or not.** Specific standards that apply to FFEs, other state-based Exchanges, and OPM-regulated plans, does not mean that each state must establish the same quantitative measurements. We recognize that each state should be able to set its own specific metric for the standard. But, all states should have quantitative standards, not just FFE states.

§156.230(d) – We support the proposed quantified minimum threshold for FFE states, based on time and distance standards. We urge that the minimum threshold be applied to all states, not just those doing business with the FFE. **We encourage HHS to require that all states adopt basic network adequacy principles, including time and distance standards.**

In addition, **we think the minimum threshold could go further, to include not only standards on maximum time and distance to providers, but also provider-covered person ratios, and timely access**. States that offer innovative programs that capture network adequacy better using other metrics could petition HHS to waive the minimum requirements. But for other states, there should be minimum expectations to ensure that consumers across the country have some basic network adequacy protections.

Consumers Union recommends adding a requirement for timely access to providers as a minimum threshold for network adequacy. Timely access standards that address and enforce quantitative waiting times for appointments with providers are essential to ensure that consumers are actually seen and get the care they need when they need it. In response to the question in the Preamble, **we also believe that having different wait time metrics for a primary care visit as compared to a specialist visit would be acceptable** (and is included in the network adequacy standards for wait times in California).[13]

The Preamble states that for plan years beginning 2017, HHS is considering using network adequacy standards established for Medicare Advantage. **Using Medicare Advantage as a model for network adequacy concerns us**, given the Fall 2015 report from the GAO[14] that Medicare Advantage network adequacy requirements need better scrutiny. As noted in the GAO report, Medicare Advantage network adequacy standards consider neither how often a provider practices at a particular location, nor whether a provider is accepting new patients. Moreover, the

[13] Timely Access to Care standards, California Department of Managed Health Care. Available at https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx#.VnBc_xorLc4

[14] Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy. General Accounting Office, September 28, 2015. Available at http://www.gao.gov/assets/680/672236.pdf

GAO points to the fact that there is no clear requirement for regulators to assess the adequacy of the data used to meet the network adequacy standards.

This tells us that in addition to certification standards, there need to be clear regulatory requirements that states (and the FFE) monitor and enforce the network adequacy standards in an ongoing basis. To that end, **Consumers Union encourages HHS to add additional provisions to (d) that impose requirements on the FFE and states to actively monitor, assess, and enforce network adequacy standards**.

(2) While we understand the need for some flexibility for variances based on factors such as the availability of providers or local patterns of care, **the regulations should include a consumer protection provision that requires alternative processes to ensure that consumers retain access to care.** For example, when variances from the standard are granted for local conditions resulting in provider shortages in a rural location, insurers should be required to compensate consumers for travel that is above the base standard, so that consumers can still access care, despite the shortages, without the additional financial burden to pay to travel far to access care.

We are also troubled by language in the Preamble that states that multi-State plan options will have different network adequacy standards established by OPM. The Affordable Care Act requires HHS to establish network adequacy standards for *all* issuers seeking certification as QHPs.[15] If OPM wishes to impose stricter standards on multi-state plans it could do so. **We urge HHS to follow the mandate of the ACA and establish national minimum standards, as described above, for all QHPs, including multi-State plans otherwise governed by OPM, in order to ensure that no matter where a consumer lives there will be some specific, minimum assurance of network adequacy.**

For meeting the network adequacy standard, while we are opposed to in-network provider tiering, if it is permitted **Consumers Union urges HHS to include in regulatory language clear information that if the issuer uses in-network tiering, only the lowest cost-sharing tier's providers are counted toward meeting the network adequacy requirement**.

§156.230(e) – Provider transitions - *(1)* We appreciate the expectation that issuers in an FFE must make good faith efforts to provide written notice in advance of a provider leaving a network, for whatever reason, to all enrollees who are seen on a "regular basis." First and foremost, **we urge HHS to apply this requirement to all Exchanges, not just the FFE, and to include language in the regulation that when extending these expectations to all Exchanges the minimum requirements do not pre-empt any State laws that would be more consumer protective**.

Furthermore, **we urge you to set the notice obligation at a minimum of 30 days in order to provide sufficient notice to consumers** so they can "optimize their health insurance coverage and make cost effective choices." The shorter suggested period of 15 days may not be sufficient

[15] 42 U.S.C. §18031(c)(1)(B)

to find alternate providers and establish new relationships (e.g. setting up appointments to do so). Thirty days may even be too short. We also think that **the federal minimum days for notice should be the floor, and should explicitly allow states that have higher standards to retain them**.

The implementation of the words "regular basis" (referring to how regularly the patient goes to the doctor) should not be left up to the issuer to make a good faith interpretation. At a minimum, the **federal regulations should establish a floor definition of "regular basis" that would trigger notice requirements, preventing issuers or states from having a more narrow interpretation**. **We suggest that "regular basis" should be defined as having seen a provider once within the past 12 months.** Given that open enrollment is a very narrow time period, consumers are signed up for their QHP for at least 11 months with no ability to change plans. When they shop for coverage, it is often with a focus on the provider network, even if they only intend to visit a provider once in a year. Usage patterns indicate many consumers wait many months, or may not be able to get in for several months, to see a chosen in-network provider. Those consumers should still be provided notice when a provider leaves the network, even if they only had one chance to interact with the provider in the past year.

Consumers Union also urges HHS to consider creating a new special enrollment opportunity for people whose provider leaves a plan mid-year. While we appreciate the continuity of care provision to help those in active treatment, for others who sign-up for a plan that covers their doctor who they see less frequently, the importance of being able to have that doctor in the network when care is needed is still paramount. While most consumers will simply choose another doctor, for those who only chose a QHP in order to access a specific doctor, when the doctor is no longer in the network, they should be able to use special enrollment to change plans so that they can still have access to their doctor.

In the Preamble, HHS states that issuers are "encouraged" to notify enrollees of comparable in-network providers, how to access continuity of coverage, and how to contact the plan with questions. **We believe that should be a *requirement* of all issuers and call upon HHS to add a provision in the regulations that requires issuers to communicate all those things to enrollees' whose providers are leaving the network, as well as information about their right to receive transitional care from their provider if they are in the midst of a course of active treatment.**

We also strongly support the idea that any time a primary care provider leaves the network, *all* enrollees who are patients of the primary care provider should be notified, regardless of the most recent visit.

(*2*) The continuity of care provisions proposed in this section are important for consumers. Explicitly ensuring that during the continuity of care period *in-network cost-sharing rates apply* is extremely important. **Consumers union urges adding a provision stating that the cost-sharing spent during the continuity of care period explicitly applies toward the in-network deductible and the out-of-pocket maximum**. Once again, we believe that these protections

should be extended to all consumers in every state, not just those whose states participate in the FFE. The language should be clear when extending these expectations to all states, that the minimum requirements do not pre-empt any State laws that would be more consumer protective.

§156.230(f) – Out-of-network cost-sharing - We appreciate that the proposed regulations (and Preamble) address the occasions when an enrollee "unknowingly" receives out-of-network care. Consumers Union has thousands of stories from consumers across the country who are faced with what we call "surprise out-of-network bills" through no fault of their own. A *Consumer Reports* survey of privately-insured individuals found that one in four consumers had experienced a surprise out-of-network bill.[16] **It is important that the new rules take steps to address the problem of out-of-network costs for 2017 and beyond**.

Consumers Union strongly believes that current network adequacy practices are unfair to consumers, in particular in the context of in-network facility care provided by an out-of-network physician. The proposed rule, however, does not go far enough to protect consumers. While subsection (1) ensures that any money spent during an in-network facility visit applies toward the annual limit on cost-sharing, regardless of whether the care is from an in-network or out-of-network provider, it does not protect consumers from paying outrageous rates for out-of-network care before they meet those annual maximum out-of-pocket limits, including out-of-network cost-sharing and balance billing. **Consumers Union urges re-drafting this provision to also apply in-network cost-sharing rates paid toward the in-network deductible and to explicitly prohibit balance billing when an out-of-network provider cares for a consumer at an in-network facility, regardless of whether the consumer has been provided notice**.

The provision also fails to address out-of-network emergency situations and the problem of balance billing. **In the emergency context, if a consumer seeks care at an out-of-network facility, the regulations should explicitly require insurers to charge in-network rates for the entire emergency visit for both the facility and any out-of-network providers. Additionally, there should be a specific regulatory provision that bans balance billing for these events.**

Consumers Union recently explored hospital-based procedures that are more likely to be provided by out-of-network physicians practicing at in-network facilities. We found that the average out-of-network charges (known as "usual and customary charges" or "UCR") are often 500 to 1,000 percent of what Medicare pays for those same services. For example, an epidural anesthesia injection[17] CPT code with the UCR charge at the 80th percentile is 700 percent of the Medicare rate in Miami, Florida. In Tampa, Florida, it's more than 1000 percent of the Medicare rate.

While subsection (2) requires ten business days notice to consumers, in most of the situations where consumers are subject to out-of-network services at in-network facilities, they are not in

[16] Consumer Reports National Research Center, Surprise Medical Bills Survey, May 5, 2015. Available at http://consumersunion.org/research/ surprise-bills-survey/

[17] For CPT code 64479, which the code for a "single-level injection cervical/thoracic region."

the situation to benefit from advance notice or to negotiate for an in-network provider, as suggested by the Preamble. A recent Health Affairs blog[18] post by two RAND co-workers who were pregnant at the same time and covered by the same insurance plan through the same network illustrates the problem. Both women went into labor within a week or so of each other, and had their babies at the same in-network hospital. By happenstance, one of the women received anesthetic from an out-of-network anesthesiologist and had to pay an additional $1,600, while her co-worker had better luck and was treated by an in-network anesthesiologist. Even with the notice provided in subsection (2), neither woman would have been in the position, either ten business days before going into labor or during active labor, to "arrange for" an in-network anesthesiologist to give her the epidural.

From our work directly with hospitals and hospital networks, it is virtually impossible for consumers to insist on in-network providers when they do not come into contact with the type of provider before the procedure. The main doctor, such as a surgeon, may have his own referral patterns that favor certain other doctors who may not be in the same network with the main doctor. Or, the hospital may contract with provider groups, which determine who is staffing a particular shift. One consumer, with ten business days notice, does not have the bargaining power to insist that an in-network anesthesiologist be on staff when she might go into labor in order to avoid a balance bill.

If HHS continues to allow consumer notice to be the only protection against out-of-network charges or balance billing, the proposed regulation subsection needs to be revised. **Language from the Preamble should be incorporated into the actual regulation, with an explicit provision that the notice cannot be a blanket or "form" notice, but needs to be specific to the medical circumstances of the particular enrollee and must include specific charges for the services; it should list the cost of the service at the allowed or contracted rate and then the cost of the charges if the service is provided by an out-of-network provider. We also support the proposal in the Preamble that would require the notice include specific information about in-network providers.**

Consumers Union does appreciate the clear statement in the Preamble that the proposed language is not intended to preempt any State laws that would be more consumer protective. We recommend stating that explicitly in the regulations.

Standards for selecting and tiering providers

The Preamble asks for comment regarding whether issuers should be required to be transparent about the standards they use for selecting and tiering participating providers and whether HHS should have to review and approve them for the FFE before they could be used. **We do not support in-network tiering**, so would oppose the suggestion that issuers could have different tiers of providers in-network. That being said, Consumers Union strongly supports transparency

[18] A Tale of Two Deliveries, or an Out-of-network Problem. Health Affairs, November 3, 2015. Available at http://healthaffairs.org/blog/2015/11/03/a-tale-of-two-deliveries-or-an-out-of-network-problem/

and review of the standards for selecting participating providers for all QHPs, whether they are in the FFE or other state-based Exchanges. **If tiering for in-network coverage is allowed, we strongly recommend that only the lowest cost-sharing tier providers should be counted when meeting the network adequacy requirements and the standards for selection be clearly disclosed**.

Summary Measures of Relative Network Coverage

Consumers Union is enthusiastic about HHS's proposal to provide a rating of each QHP's relative network breadth on HealthCare.gov, and **we strongly urge HHS to move forward with implementing a system for rating relative network breadth**. Currently, consumers have no way of knowing what the relative breadth of their plan's network is. Particularly with the growth of plans with narrow networks and no out-of-network coverage, it is critically important that consumers understand the network that comes with the plan they are choosing and the trade-offs that come with that choice.

We strongly support HHS developing standard definitions for measuring the breadth of provider networks, along with a clear, concise rating system for communicating the breadth of the networks to consumers. Such a system will enable consumers to make better, more accurate comparisons of the QHPs available to them.

A number of studies have developed metrics for measuring and classifying provider networks based on their relative breadth.[19] In particular, we found the nomenclature used in the Leonard Davis Institute study, which classified networks as "extra small," "small," "medium," "large," or "extra large," to be particularly useful and easy for consumers to understand. However, as for all consumer-facing tools, **we urge HHS to conduct consumer testing to inform how best to display this information for consumers**.

With respect to the methodology, **we encourage HHS to factor in both physicians (primary care and specialty physicians) and hospitals when evaluating and rating health plan networks**. We believe it would be useful to provide separate ratings for breadth of network by categories of providers: primary care professionals, specialty physicians, hospitals, pharmacies, and other facilities. Consumers might also be interested in providers that specialize in certain populations such as pediatrics or gerontologists. Those specialized ratings could then be rolled up into a single overall rating of network breadth. In this way, networks with a large number of physicians but few hospitals or with a large number of primary care professionals but few specialty physicians could be more accurately analyzed and categorized.

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[19] For example, McKinsey Center for U.S. Health System Reform, "Hospital Networks: Updated National View of Configurations on the Exchanges," (measured just hospitals in network) June 1, 2014,. Available at: http://healthcare.mckinsey.com/hospital-networks-updated-national-view-configurations-exchanges. And Weiner J and Polsky D. "The Skinny on Narrow Networks in Health Insurance Marketplace Plans." Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation. (measured physicians in network) June 2015. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf421027.

Finally, **HHS should give states the option of using more rigorous standards in their determination of network breadth**. For example, if a state's network adequacy standard is based on time, distance and timely access, breadth would be measured using just those providers that also met that criteria, rather than all in the network.

§155.220 - Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs

Consumers Union recognizes the value of having a streamlined and consumer-friendly enrollment process and the ability to easily and seamlessly enroll consumers through Exchanges. We also acknowledge the important role that agents and brokers have played in helping many Americans enroll in health insurance. However, we have significant concerns about the option under consideration as referred to in the Preamble to allow web-based entities to enroll consumers through their own websites without having consumers redirected back to the Exchange website for eligibility determinations. We believe the best way to maximize enrollment in coverage through Exchanges for the future is by supporting robust outreach and education efforts (see comment below on §156.50) and continually refining and ensuring smooth operation of Exchange websites.

(c)(1) - **Consumers Union urges the Department not to allow an option that permits consumers to complete their application and enroll directly through web-based entities without first being directed to an Exchange site.** While we appreciate the requirement that web-based entities use the FFE's single streamlined application, we think it should be used through an Exchange, not through a web-based entity. Exchanges are a cornerstone of the Affordable Care Act and crucial to its success. The value of going through the Exchange websites for eligibility determinations should not be lightly discarded. Without an initial interface with an Exchange, there is a strong likelihood of future confusion when the consumers get communication from the Exchange. They will not have any connection and may disregard notices from the FFE or state-based Exchanges, for example regarding inconsistencies, needed verifications, and 1095-A statements. Retaining a requirement that consumers complete their application and enrollment through an Exchange ensures that they establish an identifying relationship with the Exchange.

Moreover, establishing the initial relationship with Exchanges ensures that consumers receive completely unbiased information. Web-based entities have contractual relationships with some insurers, but not necessarily all the insurers available through an Exchange. While the entity is required to sell all products, a web-based entity is not the same unbiased source for health coverage information that the Exchange is. The Exchange is without the influence of particular issuers that web-based entities may have contracts with. Moving eligibility determinations to a web-based entity's site risks insurer and agent special interests impacting choice decisions.

We are also concerned about monitoring and oversight if web-based entities are permitted to enroll consumers directly. It will be both time consuming and costly to sufficiently monitor web-based entity performance to ensure that consumers are provided an experience that does not

deviate from what is available on the Exchange website. Consumers Union urges HHS to gather and analyze comprehensive data on the consumer experience to date with web-based entities, making such data and analysis public, and subjecting it and any resulting specific proposal to public comment before taking any action on this proposal. If this proposal goes forward, **Consumers Union strongly urges HHS to include regulatory provisions that require strong consumer protections, along with robust audits, monitoring, and enforcement authority to Exchanges in order to ensure consumers are able to make the most informed choices, their privacy is protected, and they do not face discrimination or adverse selection**.

Our concerns about this proposal are compounded regarding the potential impact of direct consumer enrollment through web-based entities on those who are eligible for Medicaid. What would happen to consumers who start the application process through a web-based entity and are told they are eligible for Medicaid and/or CHIP? Because issuers do not pay web-based entities to enroll people into Medicaid and/or CHIP, would those consumers be abandoned to navigate their own way through the FFM or State-based Exchange? This would create a significant hurdle for a substantial portion of the low-income population eligible for Medicaid and differential treatment for such applicants. Such a complex, lengthy process might dissuade some of those most in need of coverage from completing the process. **We urge HHS to carefully consider the particular implications of direct web-based entity enrollment on this population.**

Consumers Union appreciates that the Department has specified that web-based entities be required to use the FFE single streamlined application, the same language for application questions, and the same sequence of information to determine eligibility. We strongly believe this consistency is important for consumer understanding. **But we believe the rules should also explicitly ensure that web-based entities are required to**:

- Provide consumers with the ability to anonymously explore or search the website to learn more about the health coverage programs and plans available to them, including insurance affordability programs. Consumers should be able to explore the website without being required or prompted to share information beyond the minimum information needed to generate a premium: ZIP code, or age for each family member seeking coverage.
- Prior to requesting personal information, notify consumers how individually identifiable information is collected, used and disclosed. (See more detailed comment on §155.260 below.)
- Not use confusing, look-alike data elements such as "customer reviews," "quality ratings" or "best seller" designations that are less robust than or contradictory to similar items found on the healthcare.gov (such as standardized quality ratings).
- Post a clear and prominent statement on every page that indicates to consumers that they may go to the Exchange's website at any time to complete enrollment.
- Provide notice that the web-based entity, including any certified agents using the web-based entity, are paid for enrollment by carriers. Agents and brokers owe a fiduciary duty *solely* to the carrier, not to the consumer; consumers are often not aware of this. It is

important that consumers understand the compensation scheme in light of the fiduciary relationships.

- At a minimum, commit to the same nondiscrimination requirements as the Exchange, including access for Limited English-Proficient consumers and persons with disabilities. The web-based entity should be required to have a Spanish language web site as the FFE or the state-based Exchange, and telephone assistance in any language. They should be held to the same standard, thus making available their websites and customer service in English and Spanish and telephone assistance in any language, including American Sign Language. At a minimum, applications should be provided in alternative formats including Braille and large print font for those with visual impairments.
- Prohibit web-based entities from gathering or storing data beyond that necessary for healthcare.gov, state-based Exchanges, and Medicaid and/or CHIP eligibility and enrollment via "cookies" or other tracking tools. Also, bar web-based entities from storing or using information gathered from consumers in the application process for marketing other products.

Given that the proposal in the Preamble means that consumers will never interface with an Exchange website upon application and enrollment, we reiterate our comments raised in 2014 and **ask that the following important consumer protections be applied to web-based entities**:

- Require web-based entities to display all qualified health plan (QHP) information and data provided by the Exchange, *in a manner consistent with the display at the Exchange*, such that a consumer is able to access all of the same information as at the Exchange.
- Require prior approval before web-based entities use any display features or tools that vary from those available on the Exchange website.
- Require that web-based entity sites prominently display all consumer choice tools that the Exchange website makes available, such as the required premium and cost-sharing calculator or the ability to filter by whether a particular physician is in a plan's network. In particular, it must be made clear to consumers which plans will provide them the most affordability assistance. Consumers must be able to view the premiums and cost-sharing amounts for each plan based on what their individual costs would be (after their premium and cost-sharing assistance is accounted for).
- Require that web-based entity sites use the same display order as the Exchange website, and use the default sort order for QHP choices that is the same default sort order for the Exchange website and allow consumers to easily alter the sort order by the same options available at the Exchange. When the consumer hides or filters out choices, there must be a clear indicator that not all choices are currently displayed.

Consumers Union also urges HHS to prohibit all web-based entities, not just those doing business with the FFM, from using the words "Exchange" or "Marketplace" in the names of their websites and/or URLs. It is important that consumers be fully informed and understand whether they are using an FFM website or an independent web-based entity. There must be a clear and easy-to-understand delineation between the FFM and non-FFM web entities; allowing web-based entities to use the terms "Exchange" or "Marketplace" would undermine this

distinction and create consumer confusion. **This provision should be extended beyond the FFM, to apply to all web-based entities, even those enrolling consumers in state-based Exchange products.**

§ 155.220 (l) Application to State-Based Exchanges using a Federal platform

Consumers Union supports applying the same standards and requirements to **all** brokers who enroll qualified individuals, qualified employers, or qualified employees in coverage whether they do so through a Federal platform or through a State-Based Exchange using a Federal platform.

§ 155.260 Privacy and security of personally identifiable information

Consumers Union applauds the Department's attention to the importance of data privacy and security. Ensuring that consumers' private and personal information is safe and secure should be a top priority.

Consumers Union urges HHS to **require that, prior to requesting personal information, web-based entities inform consumers how individually identifiable information is collected, used and disclosed; for how long it is retained; and whether and how they can exercise choice over such collection, use, and disclosure**. Consumers should be informed when they have the option to provide personal information directly to the Exchange. Further, no information regarding such browsers or explorers (including her/his internet provider address) should be collected or saved (a.k.a. "cached") without the person affirmatively consenting to begin the enrollment process.

We also urge **HHS to require that web-based entities enter into uniform, detailed agreements with Exchanges as to the nature, timing and use of personal information collected about the consumer**. For example, "help me shop" tools cannot be fronts for collecting information about health status that could be used for improper steering. Like other Exchange vendors, web-based entities must adhere to the same or more stringent privacy and confidentiality requirements imposed upon the Exchange (See section 155.265(b)).

§ 155.280 Oversight and monitoring of privacy and security requirements

We applaud the Department's recognition that oversight and monitoring of privacy and security requirements are important consumer protection issues. We support HHS' proposed provision to oversee and monitor privacy and security requirements for Federally-facilitated Exchanges, State-based Exchanges on the Federal Platform, and non-Exchange entities required to comply with Federally-facilitated Exchange standards. However, Consumers Union **urges the Department to propose more specificity in a rule that will be subject to public comment**.

§154.200(c)(2) 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. In our comments on the Notice of Benefit and Payment Parameters for 2016, we supported HHS' proposal to base the threshold for review on the average increase at the plan[20] level rather than the overall product level. As HHS notes here, though, this adjustment to the threshold calculation removed only some, but not all, of the avenues through which insurers may avoid rate review. Consumers Union agrees with HHS' observation that the current method of calculation allows "for an issuer to change geographic rating area factors such that members in a certain rating area receive a larger increase, even though the overall rate increase would not be subject to rate review because the plan-adjusted index rate does not increase by 10 percent." **We therefore fully support the proposal to include premium rating factors in the threshold calculation.**

As with the proposal for 2016, this modification to the calculation of rate increases subject to review may potentially increase the burden on reviewing entities—because more plans may hit the threshold for review (currently 10% increase)—however, this clarified requirement is in line with the intent of the ACA's rate review section, is protective of consumers, and is therefore justified.

Additionally, in light of the recent spate of proposed health insurance company mergers, **we urge CMS to evaluate how rate changes are quantified, particularly when one carrier becomes wholly owned by another carrier or when the merger results in an entirely new corporate entity.** In the case where a product is essentially unchanged but for the name of the insurer offering the product, **we urge CMS to consider any rate increase filing in the year subsequent to the merger as a renewal of the product rather than an entirely new filing, (which otherwise could be abused to circumvent the ten percent threshold).**

Finally, **we continue to strongly urge HHS to reevaluate its implied decision to keep the rate review trigger at ten percent**. It is not unusual for carriers to propose rate increases only slightly below the threshold. However, a 9.9% rate increase is only negligibly more affordable than a 10% increase. Rather than an arbitrary 10% threshold, **we encourage HHS to lower the bar to a threshold more aligned with sustainable rates of health spending growth.** According to the National Health Expenditure Projections 2014-2024 released by the Centers for Medicare & Medicaid Services, "for 2014-24, health spending is projected to grow at an average rate of 5.8 percent per year (4.9 percent on a per capita basis)."[21] Even with a margin for error, long term annual growth in per capita health spending growth is likely to be well below ten percent. ***It is time to lower the review threshold.***[22]

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[20] Within this comment letter, Consumers Union uses 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.

[21] Centers for Medicare & Medicaid Services, National Health Expenditure Projections 2014-2024—Forecast Summary. Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2014.pdf.

[a] For example, a threshold of 5% would be in line with national health expenditures yet still well above the general rate of inflation.

§154.215(h)(2) Disclosure of all proposed rate increases

In 2015, HHS made rate review more transparent than ever before by publicly posting proposed rate increases and rate filing justifications. While a significant step in the right direction, the agency's decision to limit disclosure to proposed rate increases of 10 percent or greater created a lopsided preview of the 2016 health insurance market. By expanding what information is disclosed to include all proposed rate increases, as suggested in the Preamble, regardless of whether the increase is subject to review, HHS will improve the quality of information available to the public. Doing so will convey the full picture to the public and make it more likely that the media will present a more balanced story. It will also aid in the rate review process by making more information available to consumer advocates to compare against rate filings that do meet the review threshold—for example, by enabling reviewers to compare the medical trends of products whose rate changes fall above and below the threshold.

Consumers Union thus supports the proposal to make public all single risk pool rate increases, and believe it should go even farther to disclose all proposed rate modifications—increases and decreases both. By excluding proposed rate decreases from the picture, HHS sets the stage for only the bad news being released without the counterweight of the good. Other than health plans, which can capitalize off of only having rate increase justifications being publicly available—because only showing rate increases impliedly justifies those rate increase—it is not clear who is served by withholding information on decreases. **We therefore urge HHS to publicly post all rate filing justifications and allow the media, consumer advocates, and consumers at large to see a more complete understanding of health insurance rates**.

§154.301 CMS's determination of effective rate review programs

In 2014, Consumers Union supported amending this section to specify requirements by providing public access to rate filing information. While we appreciate the overall increase in accessibility of information, there remain dark pockets where states failed to post information in the requisite and appropriate manner. To the extent that some jurisdictions were unable to comply with posting requirements because of challenges posed by CMS's timeline in 2015, **we support the proposal here, which gives states more notice to identify in advance any challenges the timeline may pose and to work with CMS to make adjustments to the timeline while also making rate information available to the public at a uniform time.**

We note that the advanced notice proposed here will identify for CMS, and the public, which jurisdictions are disinclined to publicly post rate filings at all. Furthermore, it is exceedingly difficult to determine the effectiveness of states in regulating rate changes when rate filing information is veiled. **Consumers Union, therefore, strongly urges CMS to reevaluate any state that continues to fail to meet public posting deadlines 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.

§ 155.335 Annual eligibility determination

Consumers Union recognizes the benefit of instituting a streamlined auto-renewal system, but we also see substantial risks to consumers to auto-enroll based *solely* on premium considerations. In response to the query in the Preamble, **we strongly oppose any hierarchy of default re-enrollment that would auto-enroll Exchange customers into a plan outside an Exchange, as this would deprive them of eligibility for any subsidies.** Moreover, for any default hierarchy, it is critically important that consumers receive timely, meaningful notice of their right to change plans and possibly achieve a lower premium and out-of-pocket costs. These notices should start with the early warnings of upcoming open enrollment and continue as a flag on written and email notices, and pop-up on websites.

We hope that HHS will revise the current regulations to achieve an appropriate balance between guaranteed renewability and accurate information to ensure that consumers in all Marketplaces remain enrolled in 2017, and do so in the plan that makes most sense to them in terms of affordability and comprehensiveness of coverage. With movement toward standardization of cost-sharing, consumers will likely focus on premiums, quality and provider networks to shop for and choose plans. By auto-enrolling and emphasizing only premiums for auto-enrollment, the current and proposed regulations do not recognize the importance of total out-of-pocket costs and of non-monetary factors that consumers consider when choosing health coverage.

§155.1000 Certification standards for QHPs

HHS' "open market" approach to QHP certification has resulted in a very wide selection of plans for enrollees in FFEs. As the commercial health insurance markets continue to evolve, **Consumers Union urges HHS to use its broad discretion to selectively contract under Part 156, so that the best products—in terms of price and quality—remain available.** The Preamble notes that HHS intends to continue to focus certification denials for the FFE on cases involving integrity of the FFE and plan, as well as past performance as evidenced by indicia such as consumer complaints, compliance issues and data submission errors. **We support HHS using such certification criteria in the near term.**

For future years, however, Consumers Union also strongly urges CMS to consider selective contracting—also known as "active purchasing"—on a more global scale. Limiting the number of carriers per state FFE would still foster competition, while affording HHS far better leverage in negotiations on price and quality. Exercising HHS' option for selective contracting in a measured way—by assessing the competitive landscape in each state, conferring with the state regulator, and assessing the operational and network capacity of the applicant plans—would allow HHS to ensure a sufficient numbers of plans offered, while maintaining bargaining leverage on both price and quality. Active purchasing is a valuable—even necessary—complement to standardized cost-sharing designs to achieve the best prices and products for

enrollees. It is that combination that has restrained rate increases and improved product offerings in California, for example. We urge you to take this route for the FFE.

§156.50 User fees

Consumers Union recommends that you closely consider raising the proposed fee for 2017, rather than continuing it at the 2014-16 rate of 3.5% for FFEs and 3.0% on state-based Marketplaces on federal platform (SBM-FPs), to ensure ongoing adequacy of marketing and outreach efforts. It is essential that outreach and education about the Affordable Care Act coverage, subsidies and obligations continue at a consistent and high level. Public programs-- and businesses-- falter without a continual, vigorous public presence. And in states with an atmosphere hostile to the ACA, where disinformation is rampant, continued marketing and outreach on the federal level for FFEs will be essential. In California, for example, public awareness about Covered California has been high and support widespread. Yet, even in such a favorable environment, in 2015 more than one-third of the uninsured did not know about the availability of financial assistance in covering premiums and out-of-pocket costs.

Maintenance and enhancement of healthcare.gov and call centers is no doubt a costly endeavor. If the bulk of the 3.5% proposed for the FFE is dedicated to those very high ticket items-- IT and call center maintenance and improvement-- few resources will be left for essential "sales promotion" and outreach activities. Covered California, for example, allocates 36% of its budget ($21 million) to outreach and marketing. In most industries, we understand that upwards of 30% of budgets are allocated to acquiring customers. Consumers Union strongly urges HHS to think on this scale.

Other resources for outreach, enrollment and public education about the Affordable Care Act and Exchanges are dwindling, as philanthropic foundations pull back from funding these activities. Thus, it will be all the more important for the federal government to pick up the slack. Funding from the user fees will be an essential source for such continued and amplified efforts. In settling on the 2017 fee, we urge you to remember that issuers have gained a great deal under the ACA. Overall, most have been highly profitable. They have been given new markets and have saved a great deal in marketing costs and broker commissions under the ACA, since the federal government and state-based Exchanges have done the lion's share of the publicity and outreach to date. Thus, raising the fee above the proposed amounts could easily be borne by QHPs without a significant effect on premiums and would give HHS a more stable budget for meaningful, continuous marketing and outreach.

Marketing and sales efforts by the federal government as the unbiased source of information and strongest proponent of the ACA, will be more critical in 2017 and future years than ever. Consumers Union, therefore, strongly **urges HHS to ensure adequate funding from user fees for public education, marketing—acquiring new customers and keeping existing ones**. The long-term success of the ACA depends on it.

§§158.103 and 158.140. Issuer use of premium revenue: reporting and rebate requirements

Consumers Union strongly opposes counting a health insurer's investments in fraud prevention activities as "incurred claims" in the numerator of the Medical Loss Ratio (MLR). The ACA delegated to the NAIC the task of recommending how the MLR is calculated. To that end, the NAIC and its consumer representatives engaged in lengthy discussions and submitted a proposal to CMS, which was adopted in 2011. Myriad experts from a broad range of constituencies engaged in lengthy discussions on the MLR. During these deliberations, the dearth of evidence supporting an argument that fraud prevention activities are directly attributable to consumer medical benefit became readily apparent. Consumer advocates, including Consumers Union, firmly believe that there are expenses that are good business practice, but administrative in nature, that do not directly benefit consumers and therefore should not be counted as medical claims. Investments in fraud prevention fit squarely in that category. The NAIC recommendation, adopted by CMS, allowed fraud recovery expenses as a quality improving activity expense *up to the amount of fraudulent claims recovered*. This was an accommodation to insurers, which consumer representatives on the NAIC were willing to accept.

While fraud prevention is important, it is ultimately an administrative task conducted by insurers to control costs and expenses. There is no basis to reopen a definition that was already explored and addressed nearly five years ago with circumstances unchanged in the interval.

In addition to the above-noted provisions, we see a number of laudable provisions incorporated throughout the proposed regulations, and here offer abbreviated comments on several:

- **Transparency of Rate Review** - We support HHS's proposed revisions to the regulatory text in §§154.215(a), (b), and (c), which would update current language to more clearly describe current policy. As drafted, the rate filing requirements are not overt on the first read, necessitating diligence and expertise to assure full compliance. It is our impression that the proposed revisions are intended to, and do in fact, make current policy more transparent by revising the structure of the wording in these three subsections.
- **Navigator Program Standards –** Consumers Union strongly supports the Department's proposed amendment to require Navigators to provide targeted assistance to underserved and/or vulnerable populations within the Exchange service area. We agree with HHS' assessment that this type of targeted assistance will improve access to health care for communities that frequently face barriers to receiving important care, have high disease burdens, and poor health outcomes.
- **Non-Navigators and CAC training –** Consumers Union understands that the new requirements regarding Navigators' post-enrollment responsibilities do not apply to non-Navigators and CACs. However, we believe that the training information about post-enrollment activity that the Exchange must provide to Navigators also should be provided as required training topics for non-Navigators and CACs since they provide similar consumer assistance. We strongly believe that it is important to ensure that all consumer

assisters have the most complete and up-to-date information so they can conduct their assistance appropriately.

- **Reporting to employers employee Exchange eligibility** – Consumers Union appreciates HHS' change to require reporting to employers regarding employee eligibility only *after an employee enrolls in a QHP*, rather than at the time she applies for coverage. We appreciate the change to ensure reporting is accurate and relevant. In addition, we agree with the Preamble statement that if an employee has applied and been determined eligible for coverage, but has *not enrolled*, that HHS should *not send* a notice to the employer as this would create confusion.
- **Alternative verification** – Consumers Union strongly urges the Department to adopt a higher threshold for alternative income verification; higher than the current 10%. Given that the tax data available to Exchanges is at least two years old, a higher percentage threshold will ensure that those consumers truly eligible for coverage do not unnecessarily have to jump through hoops, go through informal resolution or appeals, in order to determine final eligibility. We believe a threshold of at least 20% is reasonable, given that this will be based on tax data up to two years old.
- **Aging into Medicare –** Consumers Union strongly supports the Department's proposed idea of a pop-up or flag to alert potential enrollees who will be turning 65 during the benefit year of their upcoming eligibility for Medicare. The pop-up should include information and links for them to apply to Medicare, when eligible. In addition, given the repercussions for individuals eligible for Medicare if they remain enrolled in an Exchange while eligible for Medicare, we believe that Exchanges should send specific notice to each person regarding Medicare eligibility, the repercussions for failing to enroll in Medicare Part B in a timely fashion, and the tax credit implications for remaining enrolled in an Exchange while on Medicare.
- **Special enrollment –** Consumers Union strongly believes that special enrollment triggers should not require documentation for verification and supports HHS' expectation that allegations of abuse must be backed up by hard evidence before policy changes are made.
- **Medical Loss Ratio -** We support improving the accuracy of MLR calculations by replacing estimated claims liabilities and reserves with the actual claims payments. These modifications are likely to reduce potential "gaming" of MLR calculations and return to consumers more accurate rebates to which they may be entitled.

On behalf of Consumers Union, thank you for the opportunity to comment on this important rulemaking and your continual refinement of policy to realize the full promise of the Affordable Care Act.

Sincerely,

Elizabeth Imholz
Special Projects Director