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Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
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Submitted electronically: FFEcomments@cms.hhs.gov

Re: Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces — AHIP Comments

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS) Draft 2015 Letter to Issuers in the Federally-facilitated Marketplace (FFM).

Since the Affordable Care Act (ACA) was signed into law on March 23, 2010, health plans have been working diligently to implement the law's many requirements. This work started with the implementation of important provisions that took effect soon after the law's passage, including the extension of dependent coverage up to age 26 and the elimination of cost-sharing for preventive benefits, and has been ongoing since that time.

In our previous comments on the ACA's implementing regulations and guidance, AHIP has emphasized the importance of a regulatory environment that promotes a wide range of affordable coverage options. The goal of affordability remains just as important today as it did in advance of health plans' initial filings and the beginning of last year's first open enrollment period. Policies that increase the cost of coverage or restrict consumer choice may encourage individuals to forego purchasing coverage until they are sick or injured. This is particularly true for young and healthy individuals – a key demographic of the reformed marketplace, but one that is extremely sensitive to the cost of coverage. We remain concerned that adverse selection and unnecessarily high costs will occur in the absence of broad market participation.

As was the case leading up to the 2014 open enrollment period, health plans are focused on developing innovative, comprehensive, and affordable options for the 2015 benefit year. We continue to encourage the Department to adopt a regulatory framework that broadly supports affordable coverage in the new health insurance marketplace as a complement to these efforts. It is through this lens that we offer the following general comments regarding the Draft 2015 Letter to Issuers in the FFM.

Stability in the FFM is Critical for 2014-2015. We believe it is critical to continue on a constant, stable path until all aspects of the FFM are fully functioning from end to end. Throughout open enrollment, our policy and operational experts – as well as experts from across our member plans – have offered expertise and resources to address issues that have arisen, and we look forward to continued work with you in that regard.

Challenges Remain Heading into the 2015 Benefit Year. While functions at *healthcare.gov* and the overall enrollment process continue to improve, significant issues remain. Health plans continue to dedicate significant resources to efforts to help address the range of enrollment issues that have arisen, such as duplicate enrollments, missing 834s, and special enrollment periods granted for FFM errors, many of which involve utilizing manual processes and workarounds. Other core functions such as enrollment reconciliation and payment are not yet operational. Instead, CMS has asked plans to utilize interim processes until systems can be developed and tested. Complicating all of this work is a lack of clear, written guidance on the many operational and policy issues that have arisen throughout open enrollment.

Thus, while progress has certainly been made in the implementation of the FFM, it is clear that much work remains to improve the FFM's functions. Improvements are not just necessary for a more efficient operation of the FFM but also to ensure a more positive consumer experience – one where consumers can be assured they will be given accurate information and their concerns will be addressed quickly and accurately.

Therefore, we were very concerned that the Draft Letter contains numerous suggestions of rulemaking that is forthcoming, including rulemaking for the 2015 benefit year. For example, on page 1 of the Draft Letter CMS notes, "Additional requirements may be included in upcoming regulations….QHP issuers in FFMs may also be subject to other requirements for the 2015 certification year, as made in future rulemaking." Throughout the letter, CMS goes on to reference potential rulemaking in a range of areas, for example:

- New standards for assessing network adequacy, including time and distance standards.
- New requirements for assessing access to Essential Community Providers (ECPs) in plan networks.
- New guidelines for clinical appropriateness of prescription drugs in evaluating benefit design.
- New requirements to cover temporary fills of non-formulary drugs or other services when transitioning to a new plan.
- New benefit requirements mandating that plans, or at least one plan at each metal level per issuer would be required to cover three primary care office visits prior to meeting any deductible.

- New petition process issuers would be required to use if they needed to modify their QHP applications.

That CMS would consider rulemaking in all of these areas – when the application process for 2015 is just a few months away – is of great concern. Only when a fully functioning, stable system is achieved do we believe it is time for CMS to propose such adjustments to the program. Further, the above examples illustrate what we view as a significant change with CMS moving away from a model that emphasizes the long-standing primacy and expertise of states as regulators of commercial insurance toward a model with more federal requirements. Instead of building an inflexible regulatory model run out of Washington, we urge CMS to continue on a path that allows states to maintain a critical role in their oversight of health insurance. In addition, we urge the agency to consider the impact of these new requirements and mandates on efforts to keep coverage affordable.

Good Faith Compliance Approach Should be Extended through 2015. Given the continued focus in 2015 on new regulations, technology, processes, and procedures, we urge CMS continue to continue to recognize good faith efforts regarding compliance through the 2015 year. The key to promoting an effective partnership between FFM issuers and the Marketplace while the program begins its 2015 launch is to recognize the efforts by all parties to promote an effective consumer-oriented Marketplace that provides affordable quality choices. The Exchange, SHOP, and Eligibility Appeals Final Rule acknowledged the transitional nature of the 2014 benefit year, and, importantly, decided not to impose civil monetary penalties or decertification for non-compliance with certain Marketplace requirements if a QHP issuer has made good faith compliance efforts. CMS acknowledged that, at the appropriate time, it would consider an extension of this approach. We urge CMS to extend this treatment and to engage in an appropriate rulemaking to formalize this approach.

More detailed comments regarding all of these areas are included in the attached detailed comments. AHIP remains committed to successful Exchange implementation, and would be pleased to discuss these comments with you in detail with you at your earliest convenience.

Sincerely,

Dan Durham
Executive Vice President
Policy and Regulatory Affairs

AHIP's Detailed Comments

Chapter 1: Certification Process and Standards for Qualified Health Plans

Section 1: FFM QHP Application Certification Process

Renewing Plans. CMS states that issuers will be required to submit a complete QHP application for 2015, including plans that were certified as QHPs for 2014. We urge CMS to allow carriers who offered QHPs in 2014 the ability to modify these existing filings and retain both their HIOS Issuer IDs as well as each plan's QHP IDs (also referred to as the Standard Component ID). Changing these IDs would be extremely disruptive both for consumers (in not having the option to remain enrolled in their current QHP) as well as for plans in supporting the electronic file transfer between the Exchange and the plan. Specifically, we recommend that benefit changes made to meet actuarial value and remain at a specific metal level be treated as a modification of coverage to an existing plan. Consumers in such plans would be advised by the issuer of any rate or benefit changes and would still have to option to select any other coverage offered in their area during the open enrollment period or remain in their current plan if they wish to do so. We are very concerned with any approach that would treat such minor modifications as a discontinuation of existing coverage. This would cause significant confusion and disruption for consumers during open enrollment and would put additional stress on both state based marketplaces (SBMs) and the FFM in having to re-enroll or change enrollments of large numbers of existing enrollees on the Exchange website when they could remain enrolled in their current plan.

Timeline and General Process. CMS notes that it will allow issuers additional time to view and correct their plan data during the certification process. For example, with the exception of states that are performing plan management review, CMS notes that plan preview will take place concurrently with the QHP application submission and review. In addition, CMS plans on giving issuers the opportunity to upload revised data templates on an as-needed basis until the final QHP submission deadline in early September. In the case of states performing plan management review, CMS has an obligation to work in earnest to assure the smooth operations of the data coordination and interoperability with the SERFF system. States utilizing that system are relying on CMS to prioritize that activity as well, so that there are not delays or systems challenges based on last minute changes made by CMS. We note our concern that the Uniform Rate Review Template (URRT) has not been made interoperable with the SERFF module as had been proposed by CMS last year, so issuers will have to submit the plan rates in both HIOS and SERFF again, leading to additional administrative burden and costs on issuers.

We welcome additional opportunities to review and update plan data throughout the QHP certification process and believe such an approach has the potential to ensure a more efficient process for issuers as well as for CMS. As you know, the success of such an approach depends

on having the infrastructure available to support it – that is, a stable plan preview environment that mirrors the same code and infrastructure that will display plans on Plan Compare; a defined process and timeline for identifying, reporting, and resolving issues; and clear, written guidance on resolving identified issues throughout the plan submission and certification process. We would welcome the opportunity to discuss ways we believe the certification process could be made more efficient for both issuers and CMS, which will also help ensure fewer errors when plan finder goes live in the fall. Our comments on the QHP templates from December 2013 included additional technical recommendations to ensure a successful plan submission process to ensure correct and accurate information is displayed to consumers leveraging lessons learned from the 2014 filling process.[1]

Regarding the specific dates outlined in the draft Issuer Letter for FFM states, we have the following comments:

Proposed Timeline FFM	**Comments:**
Initial Plan Preview – May 26-June 27	Appreciate opportunity for concurrent plan preview at this stage and throughout certification; note that modifications to timeline may be necessary if concurrent plan preview process does not function as intended and plan data cannot be immediately displayed.
First Issuer Revision and Resubmission – July 29 – August 10. Second Issuer Revision/Resubmission – August 26- September 4.	Appreciate additional time for revision; again note possible need for additional flexibility dependent upon success of concurrent preview/revision process.
CMS "locks down" data – Sept 20 Agreements sent to issuers – October 14 Agreements due back to CMS – October 17	We ask that CMS clarify whether information on QHP application status will be available to issuers between data "lock down" and when agreements will be sent. We are concerned about CMS allowing only 3 days for issuers to sign and return agreements and urge additional time – 14 days – for this process especially if major changes to the agreement are proposed for 2015. Additional time will also be necessary if the model agreement is not finalized until later in the overall certification process; we

[1] AHIP Comment Letter in Response to Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations for the 2015 coverage year, published in the *Federal Register* on November 1, 2013 (78 FR 65656).

	urge that CMS allow ample time for review and comment of the draft agreement. We are concerned that an October 17 deadline for agreements may not afford enough time to prepare for the open enrollment launch on November 15 and may also not comport with some state timelines.

Process for States Performing Plan Management. We are concerned that the proposed process does not allow adequate time for plan preview in FFM states where the state is performing the plan management function. In the current timeline that is proposed, issuers in such states would not have their first plan preview available until August 12. We suggest plan preview for those states be moved to June 1st, giving additional flexibility in the timelines to ensure that issuers in such states have adequate time to review information displayed during plan review and submit necessary corrections, and also to allow the plan management states the chance to preview the data. In addition, we suggest that CMS consider allowing for SERFF data transfer on an ongoing basis versus the two designated times noted in the timeline. Finally, we urge CMS to coordinate closely with state regulators to ensure that they are apprised of any changes in HIOS and have access to HIOS filings as quickly as possible.

Plan Preview. We urge CMS to consider enhancements during plan preview that will help ensure a better experience when open enrollment begins. Specifically, we suggest that CMS provide issuers with the ability to test any combination of demographics, case characteristics and benefit plans during plan preview versus a limited set of scenarios defined by CMS. Further, we suggest that the plan preview environment use a similar code base and replicate what consumers see on *healthcare.gov*. Such an approach will greatly reduce the volume and severity of any unintentional display errors in health plan benefits and rates once data is available to consumers at *healthcare.gov* during open enrollment, leading to a more positive consumer experience. Replicating the *healthcare.gov* environment in plan preview will also allow issuers to see directly how benefit information and explanatory information will be displayed to consumers, thus providing the capability to make adjustments to information to eliminate any potential consumer confusion.

FFM Review and New "Petition Process." CMS notes that it intends to implement a "petition process" for receiving requests from issuers to make changes to their QHP applications once the process begins. CMS states that this process would apply to changes it views as "particularly significant," such as service area changes and that it intends to release further guidance regarding such a process.

We are very concerned that CMS intends to issue new proposed regulations or sub-regulatory guidance for the 2015 benefit year when the QHP application process is set to start in a few short months. Ongoing and increasing numbers of changes implemented through the use of FAQs and Bulletins have made implementation of the 2014 exchange marketplaces very challenging. Stability in requirements is very important, and we request that CMS operate in a standard regulatory fashion when it proposes such significant market changes and rules by allowing appropriate time for public review, feedback, comments, and review by other agencies.

We are also concerned about CMS imposing broad limitations on what can be changed during the QHP application process. After the QHP application process begins, issuers may need to revise their applications for a variety of reasons, such as changes to service area based on ongoing contract negotiations with providers or requests by a state's Department of Insurance. In some instances, an issuer may seek to broaden a QHP's service area, but this new process would appear to make changes more difficult. The Draft Letter suggests that such expansions would be allowed under "limited circumstances" and when the state or CMS determines there is "unmet consumer need." We encourage CMS to ensure that flexibility to modify applications remain in place for the 2015 QHP application cycle.

Review of QHP Rates. CMS generally outlines a process consistent with that for the 2014 benefit year where it says it does not plan to duplicate reviews that a state is already conducting to enforce state law and that it will take into consideration agency reviews conducted on behalf of a state that does not have an Effective Rate Review program. We support deference to states' authority and oversight over rates. Further, we recommend a clear statement that CMS will accept rate determinations made by states with Effective Rate Review programs, as their rate review process has already been reviewed by HHS. We also support efforts to ensure consistency between the timelines for QHP certification and rate review, which will lead to a more efficient process overall.

CMS also notes that it will conduct an "outlier analysis" to identify rates that it believes are relatively high or low for a rating area and will consider a state's assessment of such rates when determining whether certifying the QHP would be "in the interest of consumers." We strongly urge CMS to provide details regarding how such an outlier analysis will be conducted as well as how it would consider a state's assessment in making its decision. Again, we urge CMS to defer to states' experience and expertise in this area and believe it would be in the interest of all stakeholders for CMS to provide the details of its proposed approach, including a CMS justification of any decision that is contrary to state recommendations.

Chapter 2: Qualified Health Plan Certification Process in FFEs, including State Partnership Exchanges

Section 2: Network Adequacy

We have several, significant concerns regarding CMS' proposal to require issuers to submit their networks to CMS for review of whether they meet a "reasonable access" standard. First, the proposed changes are a significant and unnecessary departure from how network adequacy is reviewed today. Second, we are very concerned that such significant changes and rulemaking are being considered so close to the beginning of the application submission process. Third, we believe CMS' proposed approach will be practically difficult – if not impossible – to implement, particularly for the 2015 benefit year. Network development – from creation of the network model to the discussion and negotiation with providers and signing of contracts – is a complex and critical function in the design of any health plan that can take upward of a year or more to complete. CMS' proposed insertion of oversight late in the process could jeopardize timely finalization of plans and rates. Fourth, we are concerned that CMS' proposed approach appears grounded in out-dated models of assessing network adequacy without a necessary focus on quality.

For all of these reasons, we recommend that CMS maintain its current approach to assessing network adequacy which utilizes state expertise and issuer accreditation and that CMS refrains from collecting issuer lists of their in-network providers. Accreditation is a long-standing, widely-accepted process for assessing network adequacy which incorporates a focused review of local health care markets and dynamics. Further, state insurance departments are well positioned to continue their historical oversight role in this regard, as they also have substantial expertise of local health care markets to inform their evaluation and are in a better position than CMS to understand a state's unique challenges that may impact network access standards.

If CMS decides wants to pursue the strategy outlined in the Draft Letter – placing CMS at the center of key insurance market changes, such as network review – we strongly urge the agency to do so only through a formal rulemaking process with ample opportunity for comment. Further, we urge implementation of any new policies developed through rulemaking be effective no earlier than for coverage offered in the 2016 benefit year. This will allow additional experience on both consumer needs and utilization across health plan networks that will allow a thoughtful, data driven examination to what (if any) regulatory changes are necessary.

Additional detail regarding various aspects of the network adequacy provisions in the Issuer Letter are outlined below.

Network Standards Should be Grounded in Quality. We are very concerned that CMS is proposing a major shift in network adequacy standards and moving toward standards based on

outdated models of care that focus primarily on the size of the network without regard to whether the network utilizes high quality providers that can meet the needs of consumers, especially at this late juncture in preparation for 2015 filings. Network adequacy standards should be grounded in the goal of driving improvement in provider performance and quality of care. Further, evaluation of network adequacy should be modernized from the traditional time and distance standards to factor in the use of remote access strategies, such as telemedicine and mobile medical applications.

Importance of Quality and High Value Networks. Over the past several years, health plans and employers have begun to redesign benefits to encourage the utilization of higher-value providers. Relying on data relative to provider performance, health plans and employers have been able to identify providers with a demonstrated ability to deliver quality, efficient health care and offer networks comprised of these providers as part of a range of approaches designed to improve quality and preserve benefits. Health insurance plans participating in the Medicare Advantage (MA) program have likewise turned to the establishment of high performance provider networks for these same reasons and with the added urgency of attempting to mitigate the cost impact on beneficiaries of the major funding challenges currently facing the program.

Using widely recognized, evidence-based measures of provider performance, such as those endorsed by the National Quality Forum (NQF), health plans create networks of providers comprised of clinicians and facilities that perform well on measures of quality and efficiency. A recent survey of health plans examined performance measures used by private payers and found that the performance measures used in high-value networks and provider tiering programs most often focus on cardiovascular conditions, diabetes, preventive services, and patient safety. Not surprisingly, these areas of focus were consistent across other payment and delivery reform strategies as well, including accountable care organizations, patient-centered medical homes, and pay-for-performance.[2]

Health plans that use high performance provider networks must meet state and federal network adequacy requirements, and a key element of the accreditation process includes robust standards for network adequacy and access to care. Health plans are evaluated against specific benchmarks, such as the ability of members to get regular appointments, urgent care appointments, after hours care, and member services by phone.[3]. For example, traditional network adequacy standards that may be appropriate within a fee-for-service environment, such as time and distance standards, may need to be modernized to reflect a heightened focus on quality and care delivery innovations, such as team-based care and telemedicine.

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[2] A. Higgins, "Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment with Flexibility to Innovate," *Health Affairs* 32, no. 8 (2013).
[3] NCQA, "Network Adequacy & Exchanges: How delivery system reform and technology may change how we evaluate health plan provider networks," 2013.

Many of these care delivery and payment innovations rely on close collaboration between employers, health plans, and provider groups to achieve better health outcomes. Because selective provider networks can make these collaborations easier to implement and generate positive change in the patient population, health plans are incorporating high performance networks in innovative models such as patient-centered medical homes and value-based insurance design. The focus on high value providers and value-based purchasing has carried over to public programs as well through Medicare's Hospital Value-Based Purchasing Program and the soon to be implemented Physician Value-Based Modifier. Building on the quality information contained in Medicare's Hospital Compare and Physician Compare databases, CMS is able to provide enhanced payments to hospital and physicians that perform well on cost and quality metrics.

Health plans, clinicians, employers and other stakeholders have worked hard to address practice variation and promote evidence-based care delivery. Health plans, in turn, have a strong track record of implementing tools that leverage their infrastructure and access to claims data, such as clinical decision support, medical management, and analytic reports on gaps in care, to promote evidence based decision making at the point of care and beyond. The evolution of high performance provider networks is yet another part of the overall strategy to address variation in provider performance and promote evidence based care.

Consumer Needs. Health plans are committed to making sure that consumers are enrolled in health plans that meet their needs and participation among health plans offering qualified health plans through FFM remains strong. In fact, data on the FFM show that consumers have a large number of health plans to select from when making coverage choices for 2014. On average, in 2014 individuals shopping in the FFM were able to choose from 53 qualified health plans[4] some of which may use high performance provider networks. A recent poll of consumers showed that a majority of respondents (58 percent) preferred "less expensive plans with a limited network of doctors and hospitals" to "more expensive plans with a broader network of doctors and hospitals." [5]

While preferable to consumers in the abstract, it is important that consumers take the time to review the provider networks of their plan choices, including whether specific providers are part of the networks, along with the cost of coverage in advance of making a major purchasing decision. Recognizing that some consumers have preferences for specific providers in a plan's network, we support the approach outlined in the recent CMS Enrollment Bulletin whereby

[4] Health Insurance Marketplace Premiums for 2014." Department of Health and Human Services (HHS), Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief. September 2013. Available at: http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_marketplace_premiums.cfm

[5] The Morning Consult, National Healthcare Tracking Poll: August 2013, available online at http://themorningconsult.com/tracking-poll-topline-results-august-2013./

health issuers offering qualified health plans through the FFM will offer consumers the flexibility to switch to another plan under certain conditions (i.e., same issuer, same metal tier) during the ongoing open enrollment period. This will allow consumers who may not have fully understood the importance of reviewing each health plan's provider network access to a broader network if needed. In the 2015 benefit year CMS should consider additional design changes to *healthcare.gov* to put a greater emphasis on the importance of consumers reviewing each health plans' network of providers before enrollment.

Recognizing State and Regional Differences. As noted above, allowing an additional year of experience will allow for a methodical, quality-driven approach. Such an approach would also facilitate closer coordination with states and recognize regional differences in care delivery. For example, across the country there is a wide variation in the availability in care delivery, public transportation infrastructure, population density and scope of practice requirements. We are concerned that broad federal standards will not adequately take into account these differences. For example, whether or not a state allows nurse practitioners to practice as primary care providers will greatly impact the size of a health plan's network. We thus also ask that CMS coordinate with states in accepting the recommendations and standards states have made to assure that work already completed by issuers in network management, access and adequacy in response to state requirements is recognized and accepted.

Section 4. Essential Community Providers (ECPs)

General Requirements. CMS notes its intention to issue proposed rulemaking that would utilize a general ECP standard where an issuer would be required to demonstrate that at least 30 percent of available ECPs in a service area participate in the provider network. In addition, issuers would be required to offer contracts "in good faith" to all Indian health providers and at least one ECP in each ECP category in each county in the service area. CMS anticipates that all issuers would be held to such a standard for 2015 and that there would be no minimum expectation standard option as was available for the 2014 benefit year. We have significant concerns with the proposed changes to the ECP requirements and believe that CMS should retain the 2014 thresholds and policies for the 2015 benefit year. The reasons for this are several-fold.

First, as noted above, the network development process is resource intensive and requires significant lead time in advance of the application process. Changing the requirements for ECP contracting this close to the start of the application process is thus very concerning. This need for lead-time is even greater when it comes to contracting with ECPs, as many of these providers have not historically contracted with commercial plans, and the process can require additional time to connect them to issuers' claims and electronic claims filing systems, for example. We would also note that CMS has yet to publish an updated ECP list and urge CMS to do so as soon as possible. We are concerned that if there are significant changes to the list, issuers will also not have much time to reach out to these new ECPs.

Second, the requirement that the issuer make a good faith offer to at least one of each category of ECP in a county seems arbitrary, especially when a single category includes such diverse providers as DSH hospitals, cancer hospitals, and children's hospitals. For some counties, it is conceivable that this requirement essentially operates as an any-willing-provider provision aimed at ECPs. Because the requirement is that an offer be made at a rate that is equivalent to what a willing, similarly-situated non-ECP provider would accept or has accepted, this also interferes with the ability of the QHP issuer to manage contracts and negotiate payment rates based on quality, capacity, volume, and other factors.

Third, the ability for CMS to review payment rates and offers to prove good faith in the offer would appear to be sensitive competitive information, thus review of this information by CMS is particularly troubling. Such information is closely protected by issuers and could cause harm to the issuer as well as to competition if such information is disclosed.

Fourth, we are concerned that CMS' proposed approach seems primarily focused on size of the network versus other considerations, such as capacity, quality, or local market dynamics. In addition, ensuring that providers meet other health plan criteria for contracting - including sufficient office hours, electronic claims submission, credentialing and quality standards - should be a priority in assessing adequacy.

It is also reasonable to consider that standards should not necessarily be uniform across the country – assessing adequacy and appropriate thresholds in a large, rural state should be done differently than for an urban area. Other local market dynamics may also make achievement of the threshold amount very difficult, such as instances where issuers are associated with a provider group. Increasing the threshold amount could essentially require these types of issuers to contract with direct competitors when there are a small number of health systems in a given area. Another factor is plan design. This increased ECP standard may present difficulties in other scenarios, such as HMOs models where providers are required to accept risk but this conflicts with the model of care for certain types of ECPs.

Level of ECP Contracting. CMS states that issuers would be required to contract with the corporate entity named on the CMS list for that provider to be counted as an ECP under the 30 percent standard. Individual practitioners having the same address as another ECP on the list would not be allowed to be counted in calculating the 30 percent standard; and ECPs with PO Box addresses also would not be accepted.

We have significant concerns with CMS' proposed approach. We believe that requiring ECP contracting at the corporate entity level is an erroneous measure of access. Further, this approach will make the proposed 30 percent standard even more difficult to achieve as it departs from CMS' provider-level approach for 2014.

It is common for multiple physicians or physician groups operating independently from each other to occupy the same building or office space with the same address. It is also common for providers to use PO boxes for billing purposes. Not allowing providers in such circumstances to count as separate ECPs would be a serious flaw in assessing access, and the total number of providers actually providing the medical care services which the inclusion of ECPs is intended to address.

Further, requiring contracts at the entity level does not reflect the reality of how plans contract with providers today, nor how they verify and meet credentialing and quality standards. Plans typically contract with individual providers – not their corporate entity. For example, plans will contract with providers employed at a Federally Qualified Health Center (FQHC), but not the FQHC itself. If CMS believes that entity-level contracting is an accurate measure of access for certain types of providers, we urge CMS to provide their rationale for such an approach, and the means by which the performing providers would be recognized.

Justification. CMS says that if an issuer's application does not meet the 30 percent standard, it would be required to submit a satisfactory narrative justification describing how the plan's network ensures access and will increase ECP participation in future years. However, it appears that CMS does not actually expect issuers to use the justification, as CMS states it anticipates that the 30 percent standard will be feasible for issuers to satisfy.

As outlined in our comments above, we are concerned with CMS' presumption that the 30 percent standard is feasible. We agree that regardless of whether CMS continues its approach for 2014 or moves to a modified new standard, we believe that allowing issuers to include a narrative justification is extremely important. However, we also strongly recommend that it be at a summary level, rather than at a detailed entity-by-entity level analysis. For example, the justification could be used to describe situations where contracts have been offered and not accepted, preventing the standard from being reached. The narrative justification can also be used to describe dynamics unique to certain markets, such as networks that cross state lines. We recommend that CMS clarify the purpose and value of the justification and how it should be used by issuers and how it can be used as a substitute for meeting the threshold requirements. We also urge CMS to consider allowing issuers to use the justification to describe situations where ECPs have declined contracts in the previous year and thus contracts were not offered for the current year.

Section 5. Accreditation

CMS proposes to continue its phased-in approach to accreditation for QHP issuers in the FFM, especially important for new QHP applicant, or renewing QHP applicants that are finalizing their accreditation process. We support CMS' general approach and believe it will continue to support the offering of robust, high quality health plan choices to consumers.

Section 6. Patient Safety

Regarding patient safety standards, we note the recommendations included in our comments to the proposed 2015 Payment Notice, specifically: reporting of CMS Certification Number (CCN) and current accreditation standing should come from accreditation entities rather than the QHP; condition of participation (CoP) requirements should be aligned across all programs (Medicaid, Medicare, commercial); and Provider Sponsored Organization (PSO) provisions should be incorporated into the CoPs.

On page 29 of the Draft Letter, CMS indicates that QHP issuers are required to comply with patient safety standards and may only contract with hospitals and health care providers that meet specified quality improvement criteria. However, the recent proposed rule on the Notice of Benefit and Payment Parameters for 2015 only included patient safety requirements related to hospitals. CMS should clarify if the patient safety standards outlined in the proposed rule apply only to hospitals or to health care providers in general. We recommend the safety standards are limited only to hospitals at this time for the 2015 plan year.

Chapter 3: Qualified Health Plan Design

Section 1. Discriminatory Benefit Design

Outlier Analysis. CMS states that it will perform an outlier analysis of QHP cost sharing that will include a review of plans that it determines are outliers based on an "unusually large number of drugs subject to prior authorization and/or step therapy requirements in a particular category and class." In addition, CMS notes that in reviewing a plan's cost-sharing structure, it will analyze information contained in the "explanations" and "exclusions" sections of the plans and benefits template with the objective of identifying discriminatory practices or wording.

We are very concerned that under this proposed approach, issuers could be "caught in the middle" if a state has approved an issuer's contract language and CMS subsequently recommends language counter to that which has been approved by the state. Further, we are concerned that some plan designs, such as tiered networks, or prescription drug benefit designs with specialty drug tiers, could be inappropriately flagged for further CMS review. Extending the review beyond the cost-sharing provisions to the explanations, exclusions, and benefit templates may inhibit innovative benefit designs intending to better serve consumers, not discriminate against them.

Consistent with CMS' approach to defer to state authority where possible, we recommend that CMS defer to state approval of language in contract forms and exclusions. CMS should be

required to provide details regarding how any outlier analysis would be conducted. Further, we believe that any recommended changes by CMS should be pursued in limited circumstances and that CMS would be required to discuss such changes with the state prior to requesting an issuer to revise its language. Such an approach is important to ensure that standards are applied consistently and to minimize burden and potential conflicts of rules or standards.

Section 2. Prescription Drugs and Continuity of Care.

CMS states its intent to propose through rulemaking that Marketplaces may require issuers to temporarily cover non-formulary drugs, including drugs that are on the formulary but require prior authorization or step therapy, as if they were on the plan's formulary during the first 30 days of coverage for the 2015 plan year. CMS also notes it is contemplating policies regarding continuity of care requirements in other areas, such as access to specialists.

We agree in the importance of ensuring continuity of care and note that this is something managed care plans already do today as a normal course of business. Further, health plans are subject to a variety of continuity of care regulations under state law which apply to plans regardless of whether they are QHPs or are coverage sold off of the Exchanges.

There are other important considerations we urge be recognized to inform the approach to continuity of care. Arbitrary requirements regarding continuity of care could actually have a negative effect on consumers by undercutting the strategies that health plans have developed to ensure affordable, quality products. Provider networks are part of a broad array of effective, high-value strategies, which also include: financial incentives for consumers and providers to use high quality, affordable care; disease and care management for individuals with chronic conditions; prevention and wellness; and collaboration with providers on payment and delivery reforms. High-value provider networks, in particular, are a critical strategy in the new ACA marketplace in preserving benefits and affordable coverage at a time when the health insurance marketplace and health care system are undergoing sweeping changes.

Additionally, from an operational perspective, it is very difficult to understand how continuity of care requirements regarding out-of-network providers could be accomplished in a manner that protects the consumer from significant financial risk. Out-of-network providers are not subject to contracted rates and thus consumers are not prevented from balanced billing when the plans pay for services at the level of in-network provider reimbursements; these factors combined have the potential of leaving the consumer with potentially overwhelming medical bills.

As with high-value networks, formulary design is an important tool in controlling premiums. Formulary design and selection and use of generics are critical to providing affordable quality care. The Marketplace, in educating consumers, should advise them to review in detail their QHP options including the level of coverage for medications they are currently taking. Health

issuers already urge consumers for which coverage of a particular prescription drug in a formulary is important, to consult health plans prior to enrollment. If a drug is not covered on formulary, health plans offer an exceptions process for consumers to request exceptions to any formulary restrictions or other processes, such as step therapy.

The suggestion in the draft Issuer Letter which would encourage health plans to disregard the exceptions process during the first month of coverage has the potential of creating significant disruption to health plans' projections of prescription drug costs. Formularies are designed to allow health plans to achieve volume discounts and incentivize the use of safe and effective generic medications where available. Formulary design, similar to network design, is an integral piece of designing a plan to have affordable premiums.

We look forward to more dialogue with CMS around this issue and working together to identify issues regarding continuity of care that need to be addressed, and arrive at manageable targeted solutions.

Section 2. Prescription Drugs and Formulary Information

CMS states that as part of the QHP Application, issuers would be required to provide a URL to their formularies and that the URL link to direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering and cost sharing, that are specific to a given QHP.

We are concerned that the requirement to provide cost sharing specific to each QHP within the formulary would be very difficult and burdensome to implement and could be difficult for consumers to navigate. We note that consumers would have access to cost sharing information through the summary of benefits and coverage as well as other materials that tiering information would be available at the formulary URL. Specifically, we suggest the Issuer Letter to be modified as follows (page 33): "CMS expects the URL link to direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering ~~and cost sharing~~, that are specific to a given QHP, when they are reviewing their benefit and cost-sharing."

Section 7. Coverage of Primary Care

CMS states that for 2015 it is considering whether to require through rulemaking that all plans, or at least one plan at each metal level per issuer, cover three primary care office visits prior to meeting any deductible.

We have several concerns with CMS' proposed approach. First, imposing such a requirement is contrary to efforts to design value-based insurance products. Because primary care visits could be for any service, not just preventive care, such a requirement could simply drive utilization and

increase overall costs. Second, issuers are already required to offer QHPs that meet specific standards regarding the provision of essential health benefits and preventive services for no cost sharing. The addition of this requirement will further reduce benefit variability leading to less consumer choice in the plan options available to consumers. Third, CMS suggests imposing this requirement without providing any rationale regarding its need or how it would improve the quality of care provided to consumers.

In addition to the above concern, this proposed requirement is contrary to the federal tax code requirements for HSA qualified high-deductible health plans, which prohibit plans from covering any services prior to the deductible except for preventive services. Applying this new requirement – particularly to bronze and silver level plans – means that enrollees would not qualify for an HSA and would lose the tax advantages of using HSA funds for qualified medical expenses. The impact here could be significant, as a recent study found that HSA qualified QHPs account for nearly 20% of exchange offerings.[6]

Chapter 4: Qualified Health Plan Performance and Oversight

Section 2. Compliance Monitoring

The Exchange, SHOP, and Eligibility Appeals Final Rule ("Final Rule") acknowledged the transitional nature of the 2014 benefit year and as a result, CMS agreed not to impose civil money penalties or decertification for non-compliance with certain Marketplace requirements if a QHP issuer has made good faith efforts to comply with applicable requirements. CMS, in the Final Rule, acknowledged that, "[a]t the appropriate time, we will consider extending this good-faith compliance through 2015." As with 2014, 2015 remains a transitional year for the FFM and the QHP issuers. As noted above, the draft issuer letter alone sets forth a range of specific areas for additional rulemaking and policy changes. These yet-to-be issued new requirements are in addition to other rulemaking and subregulatory guidance documents that will add additional complex requirements for the FFM and the QHP issuers that built manual processes to accommodate the FFM's technical difficulties. Any new issuers entering the FFM in 2015 also will benefit from an additional year extension of this policy. In order to promote stability of the program and a focus on a successful 2015 enrollment season, we urge CMS to extend this good faith compliance approach through the end of 2015. This approach should extend to issuer attestations in the application process as well as to the 2015 QHP issuer agreements.

CMS also proposes that issuers submit a compliance plan and organizational chart as part of the certification and recertification process. Because 2015 remains a transitional year, we recommend that QHP issuers in the FFM have flexibility in compliance plan design and content

[6] White Paper: Health Savings Account Plan Availability On Federally---Run Affordable Care Act Exchanges. HAS Consulting Services, LLC. December 5, 2013.

so as to recognize that additional regulatory requirements have not yet been finalized. Flexibility remains key as, for example, the FFM has not yet started to review paper complaints received during the 2014 enrollment process and QHP issuers have not yet had the opportunity to define these areas of compliance risk.

Section 3. QHP Issuer Compliance Reviews

CMS describes how CMS will monitor QHP issuers' compliance and evaluate QHP issuers' performance in the FFMS. The draft Issuer Letter states that CMS will perform a limited number of compliance reviews to address performance issuers or non-compliance. These compliance reviews will generally use a risk-based process, based in part on the compliance monitoring (e.g., complaint data) and performance data to select QHPs/issuers for compliance reviews.

AHIP is generally supportive of a risk-based compliance review approach to identify compliance and performance issues. We note, however, that the complaint data received to date may not sufficiently reflect true performance problems, but instead the technical difficulties experienced by consumers during the 2014 open enrollment period and the lack of consumer clarity as to the role of the FFM vs. the QHP issuer. We suggest, instead, that risk-based surveillance based on documented true performance issues be the basis for identification of compliance review. This review should remain coordinated with state oversight and informed by actual consumer complaints of health plan performance, not the exchange operations' performance.

Section 5. Monitoring of Marketing Activities

CMS describes requirements in this section that supplement the requirements included in the 2014 issuer letter. Although CMS continues to acknowledge that states will review QHP marketing materials and other related documents under state law, the draft Issuer Letter encourages a new non-discrimination section be added to agreements with agents and brokers and marketing materials distributed to enrollees and to prospective enrollees. With regard to the marketing materials, in particular, CMS should not require particular marketing materials language in addition to any language the state may require. Allowing flexibility and deference to the state role with regard to marketing materials remains key to effective marketing material development and oversight. Additionally, this can reduce conflicting state and federal standards on nuances of language or frequency and timing of notices, etc., than can create unnecessary and burdensome regulatory and administrative requirement on issuers.

Chapter 5: Employee Choice and Premium Aggregation Services in FF-SHOPs

This chapter provides a range of policy, operational and technical information regarding employee choice and premium aggregation in the FF-SHOP. We urge that CMS resources

continued to focus on improving the experience and operations of the individual FFM. Despite significant improvements on the consumer-facing side of *healthcare.gov*, the FFM still faces significant challenges with back-end data errors, significant manual work-arounds, delayed functionalities along with needed work on improvements for the 2015 plan year. We urge that these issues be resolved as the FF-SHOP capability is developed and tested. Implementation of the proposed SHOP program will be complex and is untested. Therefore, we recommend that issuer testing should begin as early as April of this year to assure that the FF-SHOP can deliver the types of premium aggregation services they are proposing to offer.

In the case of employer-choice SHOP plan selections, we request that the FF-SHOP giver issuer the option to receive the enrollment and eligibility from the FF-SHOP, then bill directly.

Chapter 6: Consumer Support and Related Issues

Section 1. Provider Directory

We agree in the importance of consumers having accurate and up-to-date information about providers in a QHP's network. Issuers already make such information available today through a variety of channels, including issuer websites and call centers as well as through agents and brokers. While the majority of a plan's network remains stable throughout a year, some providers enter or leave the network for a variety of reasons. For example, some provider contracts may not be renewed on a calendar year basis. Providers may leave a network for a variety of reasons, such as moving to a different physician group. Given these dynamics, issuers work to ensure directory information is continually updated and available to consumers.

However, we are concerned that CMS' proposal to collect network directories could create significant confusion for consumers and customer service problems. For the reasons noted above, maintaining up-to-date directories is a complex process involving a significant amount of data. Recent experience by state based exchanges has illustrated these challenges, as California recently took down its consolidated provider directory due to widespread issues regarding its accuracy.

We strongly recommend that CMS not collect provider lists or provider directories for the 2015 benefit year, as this information is already easily accessible for consumers directly from issuers. Instead, we urge CMS to focus on functionality around basic certification requirements and other areas noted in this comment letter. We welcome continued dialogue on this issue and opportunities to discuss how to ensure consumers know how to obtain up-to-date provider information for QHPs.

Section 6. Transparency

CMS notes that it intends to provide details on the implementation of the transparency in coverage reporting requirements, including what information must be provided and timing of submissions, through future regulation.

As we noted in previous comments to HHS, we urge that transparency of coverage information be treated carefully, afforded confidentiality, and not unnecessarily collected to avoid unintended consequences and harm to marketplace competition that may result from an overly broad collection and disclosure of data. In order to ensure that confidential and competitive information is protected, we recommend that the Exchange collect this information at the issuer level by state, and not the QHP level. We interpret language at §156.220 requiring the provision of transparency of coverage information by "QHP issuers" as meaning issuers will be required to report aggregated information that is not at the level of a "QHP" to ensure confidential information is protected.

In addition, we note the importance that data collected by the Exchange and CMS is the same as the data collected by State DOIs for rate filings. In addition, QHP issuers must be able to designate this information as confidential and be assured it is held in trust. Exchanges should be prohibited from selling this information for secondary use. Further, transparency in coverage information should not be used for QHP certification as many of these data elements are not related to coverage. We look forward to working with CMS further as rulemaking and policies around transparency requirements are developed.