COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

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January 15, 2016

The Honorable Sylvia Mathews Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces

Submitted Electronically

Dear Secretary Burwell:

The Council for Affordable Health Coverage (CAHC) is pleased to comment on the Department of Health and Human Services' (HHS) Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued on December 23, 2015, and its related regulations.

CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership represents a broad range of interests – organizations representing small and large employers, manufacturers, retailers, insurers, brokers and agents, patient groups, and physician organizations. Our full membership list is available on our website at www.cahc.net.

CAHC's comments on specific areas of the Draft Letter to Issuers and its related regulations are below. These comments reflect the positions of the Council, but may not necessarily reflect the individual views of our members.

1. **Standardized Options**

CAHC believes the HHS proposal to introduce standard plan options into the Federally Facilitated Exchange (FFE) would reduce consumer choice and do little to enhance the plan selection process. We believe this proposal needs more examination before being adopted as the marketplaces are still nascent and such drastic changes could both hamper their development and further discourage plan participation.

Consumer Information

We are concerned about how the standard plans will be featured on HealthCare.gov. For plan year 2015, the default display on HealthCare.gov is ordered by premium costs. This encourages consumers to choose plans based on premiums alone and undervalues key factors that affect total out-of-pocket costs, such as deductibles and other cost-sharing mechanisms. The current display is also difficult for consumers to determine whether their preferred providers and/or prescribed medications are covered across their plan options. We are similarly concerned that if the standard plan options are displayed in a manner that makes them more prominent than other plan options, then consumers may be more likely to choose standard options, even when it would not be in their best interest.

Design Flexibility

The proposal would further hamper insurer flexibility to design plans to meet consumers' unique health and affordability needs. At a time when premiums are rising, particularly for exchange-based plans, plan participation is diminishing, and the affordability gap is growing, not shrinking, we find it interesting that HHS is proposing options that would further increase premiums and reduce competition.

HHS proposes to make a significant number of benefits not subject to a deductible, which limits the number of tools available to insurers to hold down premiums. Ultimately, this would raise liabilities for taxpayers in the form of increased subsidies for higher premiums. For example, the proposed standard options would exempt office visits to specialists (for Bronze, Silver, and Gold plans) and all drug coverage (for Silver and Gold plans), including specialty tiers, from the deductible. The increased costs of these benefits will be reflected in higher costs to taxpayers per enrollee due to higher premiums, which may depress enrollment. Simply put: When costs go up, coverage goes down.

Bronze Plans

The standard option design is particularly troublesome for Bronze plans. Due to the proposed constraints on benefit design for pre-deductible coverage and formulary and network tiering, insurers will be left with few mechanisms to both hold down costs and meet statutory actuarial value requirements. For example, because of these limitations, a Standard Option Bronze plan has much higher cost-sharing than is typically seen in the market today. Particularly concerning is the fact that there are only two tiers for formulary drugs – either generic or non-generic – with 50 percent coinsurance for all non-generic drugs, which is highly atypical in today's marketplace.

CSR Silver Plans

Even more concerning is the proposed design of the Standard Option Cost-Sharing Reduction (CSR) for Silver plans. Enrollees who are eligible for CSR plans have very limited incomes. The proposed constraints on benefit designs have much higher deductibles and cost-sharing than are generally found in the market, particularly for specialty drugs. While CSR plans have significantly reduced cost-sharing and out-of-pocket limits, it is possible for a beneficiary who uses a specialty drug to meet the out-of-pocket maximum in just one visit. For example, beneficiaries eligible for a Silver 94 percent Actuarial Value Variation plan have incomes below $17,655. It would likely be impossible for a beneficiary at this income level to afford $1,250 in cost-sharing for one drug during one pharmacy visit.

We are concerned this CSR proposal would negatively impact medication adherence and quality outcomes, and could result in increased health costs due to disease progression that is otherwise preventable.

Decision Support Tools

As you know, insurers have designed a wide variety of plans for the exchanges. These plans meet certification requirements, but also provide differing options that can fit consumers' unique health care needs. Using and highlighting standard plan design offerings may incorrectly signal to consumers that these plans provide better value than other plan options, which may not be the case. As such, CAHC adamantly opposes any requirement for issuers or web-broker entities (WBE) to differentially

display standard options when a non-federal exchange is used for application and enrollment. Similarly, CAHC strongly discourages any limitations on the number of issuers or the number of plan options issuers can offer at a metal level. We also oppose requiring insurers to offer the standard plan options.

Rather than implementing standard options to simplify the plan selection process for consumers, HHS should be actively working to provide consumers with access to the best consumer support tools to help narrow appropriate choices. CAHC supports for tools that help consumers prioritize their plan choices to quickly highlight best fit and high-value options based on consumer input concerning health status, expected medical needs, and other factors. These features are available and have been for years. These tools are generally much more advanced on private exchanges than they are on the publicly operated ones, however.

The Draft Letter describes the HealthCare.gov out-of-pocket cost tool, which allows consumers to indicate their expected healthcare utilization as low, medium, or high. We applaud the inclusion of such a calculator as an important first step, but this tool still has several significant limitations with regard to accuracy and producing personalized results. As such, the tool is limited in its usefulness for consumer decision-making.

Any decision support tool should provide personalized results and should take into account data from actual plan formularies and provider networks with information on tier placement and related cost-sharing. Such a tool would allow consumers to see results based on their personally expected use of common medical services, including drug utilization and the applicable cost-sharing that is expected.

HHS specifically states in the Draft Letter that data provided by insurers can allow software developers outside of the Department to "create innovative and informative tools to assist consumers in understanding plans'" provider network data and formulary designs. Current rules limit the private sector from fully providing access to tools that can assist consumers in accurately assessing plan choice and making optimal decisions about coverage. CAHC urges HHS to look to the private sector to take on more responsibility for exchange functions that are currently exclusively or primarily provided by Federal and state governments to improve access to these smart tools for consumers.

2. Network Adequacy

HHS proposed that the FFE rely on state reviews for network adequacy, but only if the state uses acceptable, quantifiable network adequacy metrics approved by the Department. If HHS determines that a state does not meet its proposed standards, the FFE would preempt state law and conduct an independent review under a federal default county-level time and distance standard.

HHS is considering using standards for network adequacy similar to those used in Medicare Advantage. It may be problematic to impose standards relevant to the Medicare population on the under-65 market, which generally has very different access needs. The National Association of Insurance Commissioners (NAIC) "Health Benefit Plan Network Access and Adequacy Model Act" (NAIC Model Act) was designed specifically for the private market and accounts for different state needs. Accordingly, CAHC recommends that HHS base its standards on the NAIC Model Act.

CAHC also urges HHS to further allow for flexibility in network design, which the proposed network adequacy floor may not currently account for. For example, innovative, high-value networks consisting of

Accountable Care Organizations may not meet the current Medicare Advantage time and distance standards, but could be of higher quality than a more open network.

CAHC recommends that HHS adopt guidelines similar to the ones established for external review where state standards are deemed as either “NAIC-parallel,” “NAIC-similar,” or lacking an adequate standard. As has historically been the case, deference should be given to state standards and processes over federal standards. Further, HHS should provide clear and timely guidance to states on the criteria used to determine whether adequate standards are in place. Similarly, when federal standards are applied, it is incumbent upon HHS to provide greater transparency regarding the operational standards it uses to evaluate network adequacy.
Over the past several years, HHS has arbitrarily imposed standards on plans sold on the FFE with relatively little guidance. Clear, understandable, and transparent standards are needed for plans to design networks and for consumers to understand them.

In addition to the proposed standards, we recognize that HHS is considering providing a rating of the breadth of each plan’s relative network coverage on HealthCare.gov by rating plans as "Basic," "Standard," or "Broad." This rating would solely be based on the calculation of the number of hospitals, adult primary care providers, and pediatric care providers that are accessible within specified time and distance standards. CAHC considers this proposal to be highly problematic and contradictory to HHS’ goal of moving from volume-based reimbursement to a value-based system. Such a rating would provide consumers with no information about the quality of networks and providers. This would also discourage plans from creating innovative network designs, such as alternative payment models within the private market. HHS should abandon this proposal or propose a rating method that would inform consumers about network quality and innovation rather than breadth alone.

3. Web-Broker Entities

HHS is considering revising current regulations, which require WBEs and insurers who use non-exchange websites to assist consumers in the plan selection and enrollment process to redirect consumers to the FFE to receive both an eligibility determination and to actually enroll in a plan. Consumers may only use the WBE’s or insurer’s site to fill out an application and shop for plans under the current rules. This process is cumbersome for both consumers and the non-exchange sites, disrupts the consumer shopping experience, and prevents these sites from providing the full extent of their services to consumers in the plan selection and enrollment process. We are concerned this may discourage some consumers from becoming insured.

CAHC supports a streamlined process that would allow consumers to remain on the WBE’s or insurer’s site for the entirety of the application and enrollment process while the WBE communicates with the FFE or an FFE-approved web service on the back-end for eligibility and enrollment. This is generally referred to as Eligibility Verification as a Service (EVaaS). An EVaaS interface would connect to an Exchange and determine subsidy eligibility without redirecting the consumer.

HHS’ proposal seeks to amend current regulations to allow such a service for WBEs and insurers through the FFE. While the current proposal appears to only apply to application and enrollment on the FFE, we encourage HHS to allow for a similar process for any State-Based Exchange (SBE) using the federal platform (SBE-FP).

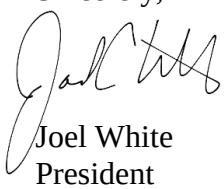
CAHC applauds this proposal and encourages HHS to allow the private sector to provide further value to consumers through plan selection and enrollment. In particular, as states struggle to maintain SBE operations, WBEs and other private, non-FFE sites may be able to serve as an attractive, more flexible alternative to the SBE-FP. We encourage HHS to consider allowing SBEs the ability to certify such entities to provide the full scope of services for consumers as a publically operated exchange.

Conclusion

CAHC appreciates your careful consideration of our comments and stands ready to serve as a resource to HHS as it finalizes the 2017 Letter to Issuers in the Federally-facilitated Marketplace. While we appreciate efforts to make coverage more affordable and accessible for all Americans, we are concerned that coverage has become less affordable and more complex for many over the last decade. CAHC urges HHS to keep this in mind as it finalizes the Letter to Issuers and its related regulations.

We look forward to working with you to ensure consumers have access to the best, most affordable health coverage options. Should you have any questions, please do not hesitate to contact me.

Sincerely,



Joel White
President

Cc: Andrew Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services
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