October 6, 2016

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

Re: Proposed Rule on HHS Notice of Benefit and Payment Parameters for 2018

Dear Secretary Burwell:

The National Health Council (NHC) appreciates the opportunity to submit comments on the Proposed Rule on the Notice of Benefit and Payment Parameters for 2018 (NBPP).

The NHC is the only organization that brings together all segments of the health community to provide a united voice for the more than 133 million people with chronic diseases and disabilities and their family caregivers. Made up of more than 100 national health-related organizations and businesses, its core membership includes the nation’s leading patient advocacy organizations, which control its governance. Other members include professional and membership associations, nonprofit organizations with an interest in health, and representatives from the insurance, pharmaceutical, generic drug, medical device, and biotechnology industries.

The NHC recognizes that this is a critical time for the long-term viability of the exchanges and the stability of the market is of increased importance. We understand and appreciate that many of the proposed provisions outlined in the 2018 NBPP seek to address insurance issuer concerns. At the same time, the NHC urges the Department of Health and Human Services (HHS) to also consider and strengthen important protections for people with chronic conditions.

We appreciate that HHS and the Centers for Medicare and Medicaid Services (CMS) have in the past worked to improve patient protections for those who are served through the exchange market. The NHC has worked closely with the administration to advocate for modifications to requirements that will support the needs of patients in exchange plans and other health insurance coverage affected by the Affordable Care Act (ACA).

Over the past few years, the NHC has focused ACA-related advocacy efforts on five key priorities developed to promote and ensure a patient-friendly exchange market: non-discrimination, transparency, uniformity, continuity of care, and oversight. These principles guide the NHC’s actions related to the exchanges and have informed our comments to HHS on previous versions of the Notice of Benefit and Payment Parameters (NBPP). While we understand the need to focus on market stability to ensure patients have access to insurance options, we are...
ultimately disappointed that HHS did not take this opportunity to improve the hard-fought patient protections that have been introduced in previous iterations of this rule. For this reason, the NHC is including comments on patient protection issues that should be addressed in this NBPP or future notices of rulemaking.

The NHC offers our comments on the proposed regulations that have the most impact on patients with chronic conditions. Since this proposed rule does not address many of the topics of concern from the patient community, the NHC also includes additional commentary, where applicable, to guide the agency’s future notices of rulemaking for exchanges in the coming years.

I. Establish an environment that removes incentives to discriminate against people with chronic conditions

Provisions Related to Non-Discrimination Included in NBPP

As previously stated, the NHC is pleased to see HHS’ continued effort to create and maintain a sustainable exchange market. However, the NHC would like to highlight some areas that, if enhanced, could better prevent discriminatory benefit designs.

Provisions and Parameters for the Permanent Risk Adjustment Program (§153.320)

The NHC supports HHS’ series of improvements to the risk adjustment methodology. Specifically, the NHC applauds HHS’ consideration of leveraging new data sources to construct the model, examining the impact of partial-year enrollments on plans’ risk profiles and including prescription drug information to determine diseases and assign severity. In particular, we believe that inclusion of prescription drug data to inform diagnosis and/or disease severity will be beneficial to the model. However, we ask that HHS share more detail about the process for selecting the specific drugs that would be included in any of the Prescription Drug Categories (RXC)s and develop a mechanism for patient organizations to provide feedback on the RXC creation.

While we believe HHS is headed in the right direction with the proposed improvements to the risk adjustment methodology and should finalize these changes, HHS should also take further steps to improve the risk model in order to stabilize the insurance exchanges. To that end, HHS should consider four additional actions:

1. Continue convening stakeholders from across the health community (including insurance companies, patients, providers, and pharmaceutical companies) to evaluate existing barriers to appropriate risk adjustment and develop new methods to address these barriers.
2. Publish data on specific conditions among patients in the exchanges in order for stakeholders to gain a better understanding of the differences between the model’s projected costs compared to actual costs for patients with specific conditions.
3. Publish information on the specific conditions included and excluded from the model and how these conditions are grouped in order to identify gaps in the model. HHS should then solicit feedback on proposals to address these gaps.
4. Perform a comprehensive study of risk adjustment across exchanges, Medicare Advantage, and Medicaid to better understand the limitations and success of each program and then apply lessons learned to improve risk adjustment for each program. Notably, HHS should study the benefit and feasibility of adding additional funds to the risk-adjustment program as is seen in other insurance markets.
We believe these four actions will help the agency uncover and begin to address the underlying issues within the current risk-adjustment model and ensure issuers are receiving accurate risk-adjustment payments that mitigate the costs of providing care for patients with chronic conditions. Otherwise, insufficient funding may make providing care for sicker enrollees unaffordable, which could result in more issuers leaving the exchange market or lead plans to structure benefits to avoid certain high-cost enrollees. While we see the risk adjustment provisions included in the NBPP as a crucial step forward, the NHC strongly encourages HHS to take further action in order to strengthen the risk-adjustment model.

Network Adequacy Standards (§156.230)

The NHC believes that the network breadth-indicator pilot will be an important tool for consumers to determine how a plan’s network compares to the breadth of other available plan networks. At the same time, the tool is not expected to offer any indication of the quality of the network or the specific providers or, even, types of specialists that are included in-network. While this tool may be of use to some patients, it does not replace the development of more stringent standards on network adequacy.

The NHC urges HHS to take a more definitive stance on the definition of an adequate network. As in prior years, the NHC recommends HHS to establish minimum thresholds for network adequacy to ensure consumers have appropriate access to all necessary providers. The NHC is encouraged by the National Association of Insurance Commissioners’ (NAIC) Network Adequacy Model Act. We support the NAIC’s recommended criteria to measure network adequacy in Section 5 of the Model Act, particularly measures to ensure provider access by specialty and geographic access. The NHC also especially supports the NAIC’s proposed standard that networks must meet the needs of all covered individuals, including those with chronic or complex health conditions. We understand the NAIC developed the Model Act as guidelines for states to build upon, but we also encourage HHS to use this as a foundation for federal network adequacy standards.

The NHC again offers model language below (in bold font) that HHS might consider in establishing federal standards for network adequacy if it prefers not to adopt NAIC model. In this concept, the NHC reiterates our stance that states should be responsible for the oversight of exchange plan networks with minimum established bounds by the federal government. For states that do not conduct reviews, a federal default time and distance standard could be used. We encourage HHS to consider implementing minimum standards for network adequacy, whether the standards be based off of the NAIC Network Adequacy Model Act or our proposed language below:

§156.230 Network Adequacy Standards

(a) General requirement. Each QHP issuer that uses a provider network must ensure that the provider network consisting of in-network providers, as available to all enrollees, meets the following standards –

(4) Includes a network that incorporates a sufficient number of providers that are accepting new patients throughout the year;

(5) Provides reasonable access to specialists and other providers who serve the needs of enrollees with rare, chronic, or complex medical conditions;

(6) Includes an adequate number of in-network providers in various specialties corresponding to the ten categories of essential health benefits;
(7) Promotes cost effective delivery of health care;

(8) Assures geographic access to in-network providers, including for individuals in urban, suburban, rural, and frontier areas, based on time and distance standards established by the Exchange.

Additional Considerations to Ensure Non-Discrimination

Since the exploration of the concept of health insurance exchanges in the ACA, the NHC and its members have focused efforts to ensure that the new marketplace had limited incentives to discriminate against patients with chronic conditions. And, though many regulations have been issued to offer guidance and structure to the exchanges, the potential for discriminatory benefits remains embedded in this market. For this reason, the NHC offers three areas for consideration as HHS finalizes the 2018 NBPP.

Definition of Discrimination

Despite the fact that the ACA prohibits discrimination, both outright and by virtue of a plan design, several analyses have shown that practices that may discourage some patients to enroll in certain plans continue even three years into exchange plan operations and state and federal oversight. While we recognize the need to address issuer concerns, the NHC believes HHS must implement provisions to protect the people who are most at-risk in the exchange plans—the patients with chronic diseases and disabilities. The NHC remains disappointed by the lack of non-discrimination provisions and urges HHS to take immediate action to address this issue.

Though HHS could define a specific list of benefit and plan requirements and prohibitions, such a list would likely need consideration and updates far more frequently than an annual rulemaking cycle would allow. Instead, we urge HHS to holistically address the issue by defining discrimination in a way that clearly describes the act of and result of discrimination. Establishing a clear and complete definition of discrimination under the ACA will enable those who experience discriminatory plan design to more easily hold parties accountable. Further, a comprehensive definition of discrimination would better guide the federal government, states, plans, and other stakeholders in recognizing and resolving discriminatory benefit designs.

Spread Total Maximum Out-of-Pocket Costs Across the Benefit Year

The annual out-of-pocket (OOP) limit is a major benefit to many patients with chronic conditions. However, the high deductibles and cost sharing of exchange plans can mean that many patients face exceptionally high out-of-pocket costs in the first month or few months of a plan year. Though many patients plan and budget for their health care costs, many of them may not have their entire annual budget for these expenses in-hand early in the plan year.

For these patients, HHS should consider options that would allow exchange plan enrollees to spread their annual health care OOP spending across the entire benefit year. Providers, themselves, have mechanisms for financing high OOP costs over a period of time; it is a regular practice of many hospitals. However, other covered services, like prescription medications, are not accessible without payment. This approach would allow patients who reach their OOP limit to pay for these services over a period of time, rather than up-front. Absent changes to rules on deductibles and OOP limits, HHS must explore this or similar options that would allow patients the means of accessing the care they need.
without requiring payment during a short window of time, particularly when enrollment extends throughout the plan year.

II. Enhance transparency standards to ensure patients have accurate information to select the plan that best meets their needs

Provisions Related to Transparency Included in NBPP

Standards Applicable to Navigators and Non-Navigator Assistance Personnel (§155.220)

The NHC is pleased with HHS’ proposal to expand Navigator duties to include post-enrollment assistance and other assistance activities, such as helping consumers file appeals and apply for exceptions. These proposals build upon previous efforts to improve the Navigator program to make it a robust assistance program for beneficiaries. Further, the NHC also supports the requirement that Navigators disclose that they are not tax advisers before assisting consumers with the tax filing process so as to avoid any confusion for patients.

Provider Transitions (156.230(e))

The NHC commends HHS’ continued effort to seek solutions in reducing patients’ surprise out-of-network charges. The option that issuers in the marketplace either count cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network provider in an in-network setting toward the OOP maximum or provide a formal written notice might alleviate some of the pressure patients feel when seeking care. Many patients unknowingly assume that if a provider offers care in an in-network hospital or clinic that the services must be covered as such. Since this is not always the case, HHS is making improvements to protect patients from high cost sharing when, in most cases, they had no intention of receiving out-of-network care. Even so, the NHC appreciates that HHS will monitor the issue and expects future clarifications of this requirement, should those be needed.

Additional Considerations to Improve Transparency

Improve Consumer Assistance Tools

The NHC strongly believes that the success of exchanges depends, in substantial part, upon a match between patient and exchange plan. When people clearly understand their plan options and actively engage in an informed process of plan selection, their expectations for health insurance coverage are far more likely to be met by the plans they select. For this reason, the NHC developed and maintained, for the first two years of the exchange market, an accurate, customizable out-of-pocket calculator that would deliver details on premiums and out-of-pocket costs for exchange plan options in their state—even including premium tax credits and cost-sharing reductions. The NHC firmly believes that patients must be matched with appropriate plans for their health care and budgetary needs.

As it has in prior years, the NHC strongly recommends that HHS improve the consumer assistance tools available on HealthCare.gov. While the NHC remains cautiously optimistic about the indicators of network breadth, these types of indicators must be meaningful to allow shoppers to clearly understand what they mean and apply that meaning to their own situations.

Though minimal changes have been proposed for the 2018 open enrollment period, the Healthcare.gov website is lacking in real, easy-to-use, accurate tools to help people sort through the dozens of plan choices available to them. In fact, HHS’ own data shows that most people enroll in the lowest premium
plans available to them, which is unsurprising given that the HealthCare.gov website sorts plans initially by lowest premium. While some individuals making this choice are selecting the right plan for them, there are many individuals who are outright confused or simply making the easiest choice. There are many changes HHS can make to improve the shopping experience on HealthCare.gov. If patients have a better sense of the services, providers, and drugs covered by the plan choices displayed, they will be better equipped to choose plans aligned with their health care and budgetary needs.

HHS must make changes to HealthCare.gov to allow patients to adjust the specific services included in each health status option of the out-of-pocket cost calculator to deliver more accurate cost sharing information. We also recommend new sorting options that allow users to sort plans using coverage of their medications, access to their specified providers, and total expected spending that combines their premium and out-of-pocket costs. The NHC believes these are essential steps to helping patients understand their health care costs and enroll in the most appropriate plan for their needs. Better matching between patient and plan could also improve duration of enrollment, which, as so many insurers have argued, is a real problem for the exchange market.

III. Apply uniform standards for plan materials and processes to ensure better patient understanding

Provisions Related to Uniformity Included in NBPP

Standardized Plan Options (§156.20)

In theory, the NHC continues to support the concept of standardized options, which consist of consistent cost sharing across a key set of EHBs in the individual federally facilitated exchanges (FFEs). Standardized benefit designs have the potential to simplify the shopping experience and result in more informed enrollees with appropriate coverage. However, it is unclear to us whether patients who have purchased standardized plans (in states that require them) fare better than those in non-standardized plans. Therefore, we urge HHS to work with states with required standardized options to study beneficiary satisfaction to inform further development of policy in this area.

Last year, we expressed our concern regarding some benefit design elements, namely the high deductibles and cost-sharing requirements for drugs placed on the specialty tier. For 2018, we would like to reiterate these concerns, as we believe they are still relevant. The deductibles and cost sharing for standardized plans remain higher than other individual exchange plans. The average combined deductible for silver plans in the 2016 individual exchange was $3,075, and the average specialty tier coinsurance for silver plans in 2016 was 34 percent.1 In comparison, the 2018 proposed silver standard benefit option has a medical deductible of $3,500 and a separate drug deductible of $500. The proposed silver standard benefit option also has a specialty drug coinsurance of 40 percent. The standard benefit option’s higher deductible and specialty tier coinsurance could be significant financial hurdles for patients. The NHC has grave concerns that the creation and promotion of these standardized plans, rather than improvement of the patient experience, might normalize such high cost sharing, encouraging such designs to spread even to non-standardized plans.

The high cost for consumers is particularly relevant for 2018 because the standardized options will be displayed differently than the rest of the plan options on the exchange. Depending on the display, this

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1 Avalere PlanScape®, a proprietary analysis of exchange plan features, December 2015. Avalere analyzed data from the FFM Individual Landscape File released October 2015 and the California and New York state exchange websites.
could lead consumers to believe that standardized plans may be their best options, or worse, their only options. The high deductibles and cost sharing for these plans might even deter some shoppers from enrolling at all. HHS must ensure that all plan options are communicated clearly for consumers to choose the best plan for them, despite the indicator for standardized plans.

Levels of Coverage: Bronze Plans (§156.140)

The NHC applauds HHS’ proposal to align catastrophic and bronze plan benefits. We believe that providing a service equivalent to at least three primary care visits before the deductible in bronze plans will provide more robust coverage to patients that select plans in this level. The NHC is also encouraged by the fact that plans may choose not to subject to a deductible one or more benefits from a set of specific services: primary care visits; specialist visits; inpatient hospital services; generic, specialty, or preferred branded drugs; or emergency room visits. As HHS considers this provision, the NHC also recommends including a prominent indicator that clearly notes which services are available before the deductible to ensure patients understand the benefit design. Even so, the NHC expects HHS to closely monitor the patient experience while shopping on HealthCare.gov as well as the influence the indicator might have on enrollment selection and experience in the plan.

Additional Considerations to Improve Uniformity

Standardization for Specific Plan Materials or Processes

In order to help patients better understand their plans and options, HHS should require standardization of plan materials (materials other than the Summary of Benefits and Coverage document) and exception and appeals processes, as are currently in place in the Medicare Part D program. By establishing a uniform template for all plan materials, patients will be able to better compare plans, benefits, and cost sharing. Additionally, for the many patients that will need to file for appeals or exceptions, HHS should consider developing a standard process that all plans must follow. Not only would this benefit patients, but a standard process could ease burdens for the provider community and health plans that must review these requests.

IV. Ensure continuity of care options for patients to protect those transitioning between coverage options

Provisions Related to Continuity of Care Included in NBPP

Guaranteed Renewability of Coverage (§147.106)

The NHC is encouraged by HHS’ proposal to relax their previous interpretation of the five-year ban for issuers that exit the market, but we also have concerns regarding potential unintended consequences. While the NHC recognizes that this proposal could potentially provide stability among issuers participating in the exchange, we caution HHS on the potential ramifications that unwise plan transitions could have on enrollees, particularly those who do not make an enrollment choice. Patients likely selected their original plans for specific reasons and transitioning enrollees to a different plan could interrupt their care. Generally, the NHC supports policies that stabilize the exchange market, however, this provision should include a series of key protections for enrollees affected by such plan transitions.
Issuer Participation for the Full Plan Year (§156.272)

We urge HHS to finalize the proposal requiring all QHP issuers to make their QHPs available for enrollment throughout the full plan year. Full plan-year participation ensures that consumers will have access to all plans, whenever they may become eligible for QHP coverage.

Direct Enrollment in Exchange Coverage through an Issuer or Web-Broker (§155.220; §156.265; §156.1230)

The NHC supports HHS’ proposal to directly enroll consumers from web-broker and issuer websites into exchange coverage. We believe that this proposal would streamline the enrollment process for consumers and remove the additional burden of being transferred from person to person.

V. Continue to assert HHS’s oversight authority of exchange plans to address the needs of patients with chronic conditions

Provisions Related to Oversight Included in NBPP

QHP Issuer Participation Standards; Non-Certification and Decertification of QHPs (§156.200; §156.290(b))

The NHC supports both HHS’ clarification that all QHP issuers must offer at least one silver-level and one gold-level QHP in each service area and the proposal to require QHP issuers to inform consumers if the issuer is denied certification for the next plan year. Both these policies will better inform patients and allow them to access the most appropriate and affordable plan in their area. We also believe these proposals are prime examples of how HHS can assert their federal oversight authority to improve patient protections and urge HHS to take further action in future notices.

Conclusion

The NHC believes that, with some important modifications, the approach outlined in the proposed 2018 Notice of Benefit and Payment Parameters could improve care for exchange enrollees; however, HHS must continue to provide more rigorous patient protections to ensure adequate coverage. We stress that in order for exchange plans to work to meet the needs of the millions of individuals who rely on coverage from the exchanges, some provisions need to be strengthened in forthcoming regulations.

As the voice for those with chronic diseases and disabilities, the NHC believes that broad patient protections in the Notice of Benefit and Payment Parameters make for a better market and will encourage higher and more consistent enrollment, while also improving care and access for vulnerable patient populations. As HHS and CMS finalize the 2018 Notice of Benefit and Payment Parameters, the NHC strongly encourages the Agency to include the above-referenced level of patient protections.

Please do not hesitate to contact Eric Gascho, our Vice President of Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable by phone at 202-973-0545 or via e-mail at egascho@nhcouncil.org.

Sincerely,

Marc Boutin, JD
Chief Executive Officer