

COMMENTS to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, CMS-9937-P

RE: HHS Notice of Benefit and Payment Parameters for 2017

By Georgians for a Healthy Future

December 18, 2015

Georgians for a Healthy Future respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) Benefit and Payment Parameters for 2017, released on November 21st, 2015.

Georgians for a Healthy Future (GHF) is a nonprofit consumer health advocacy organization based in Atlanta, Georgia. We have been actively engaged in monitoring and advocating on Affordable Care Act implementation issues that impact health care consumers in our state. More recently, GHF has been monitoring and actively engaged in state-level policy development around health insurance issues impacting how consumers shop for, access, and experience care through insurance.

GHF greatly appreciates the opportunity to provide comments to the proposed Benefit and Payment Parameters for 2017. The proposed regulations include many important steps forward for consumers. We applaud CMS for strengthening consumer protections in the proposed regulations, especially in network adequacy standards, qualified health plan certification standards, and the attention paid to vulnerable populations. In addition, there are areas the regulations could be further improved to support consumer access to high quality health care. We focus our comments both on the advancements these proposed regulations create for consumers as well as areas where they could still be strengthened.

Part 154 – Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

§154.215 Submission of Rate Filing Justification

- 1. We applaud CMS's decision to require that issuers submit a Rate Filing Justification for all single risk pool coverage products in the individual, small group or merged markets.** We agree that premium increases cannot reasonably be monitored without evaluating the net effect on premiums, including the impact of rate decreases, plans with unchanged rates, and new plans' rates. By expanding what information is disclosed to include all proposed rate increases, HHS will improve the transparency of information available to consumers to compare the medical trends of products. Although we support this proposal to expand the number of justifications disclosed to the public, we recommend that all proposed rate modifications be publicly disclosed. By excluding proposed rate decreases from the picture, HHS does not give consumers a complete understanding of the changes in insurance rates.

§154.301 CMS’s Determinations of Effective Rate Review Programs

1. Public access to information about proposed and final rate increases with a mechanism for public comment is crucial to helping consumers understand rates. While the proposal takes important steps to ensure consumers have access to proposed and final rate increases, **we recommend adding the following requirements for a state to have an effective rate review program:**
 - a. **A sixty-day comment period on all proposed rate increases;**
 - b. **The state’s website should prominently display all filing documents so that they are easily accessible, and should include consumer friendly rate summaries.**

2. **Additionally, we urge CMS to make information on final rate increases publicly available prior to the first day of the annual open enrollment period.** We recommend that final rate increases should be made available at least 15 days prior to the start of the annual open enrollment period. This will allow consumers and enrollment assisters to become more familiar with the premium rates, which will lead to more informed choices when it comes time to pick a plan that is right for the consumer.

3. Lastly, it is difficult to determine the effectiveness of states in regulating rate changes when rate filing information is not prominently posted. Therefore, **we recommend HHS to reevaluate any state that continues to fail to meet public posting deadlines before being designated or allowed to continue their designation as having “effective rate review” status.** That additional scrutiny would consider whether filings are available via alternate means, the degree to which the state gives consumers opportunities to participate in the review and commenting process, and the overall transparency of the state’s rate review process.

Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

§ 155.1000 Certification Standards for QHPs

1. We applaud CMS for considering active purchasing authority in order to provide consumers with high value, high quality plan options. In considering this new approach, **we recommend that CMS create a transparent process that considers input from a multitude of stakeholders, including consumer advocates and consumers, when identifying the standards on which plans will be selected.** We agree, as noted in the proposed rule, that CMS could assess QHP performance based on compliance reviews and complaints from consumers. Input from stakeholders will be crucial to understanding QHP performance and past consumer experience.

§ 155.170 Additional Required Benefits

1. **We urge CMS to conduct transparent, continuous, and meaningful oversight of EHB base-benchmark plans and subsequent plan benefit packages that will take effect at the beginning of 2017.** We also urge CMS to provide a clear and publicly available timeline of how CMS and states should enforce and monitor EHB. We believe CMS can accomplish this by:

- a. Considering the comments and concerns from the EHB base-benchmark plan process that would take effect beginning in 2017, particularly from consumers and consumer advocates who are in touch with EHB gaps for enrollees.
 - b. **Spot checking state-approved QHPs for compliance with federal requirements**, such as Section 1557 and the 2008 Mental Health Parity and Addiction Equity Act. CMS should determine whether these plans violate the ACA by mirroring gaps in EHB benchmarks, or through other coverage design issues, and enforce compliance.
2. **We also urge CMS to clarify the process of how states decide what is in “excess” of EHB.** We would like more guidance on what constitutes enactment that is directly attributable to state compliance with Federal requirements. We think that giving more examples and explicit guidance will empower states to know that they have the flexibility to enact certain mandates without cost.

In section 155.170(a)(3) of the proposed rule, CMS proposes designating the state as the entity that identifies which state-required benefits are in excess of EHB. While we agree that state regulators may be more familiar with EHB and should in general exercise authority to monitor and enforce compliance, **we ask that CMS conduct regular QHP spot-checks to ensure that the rule is uniformly applied across states and not being used to discourage enrollment of individuals with high medical needs.**

3. **We recommend that CMS establish a process to enable additional state-required benefits that are in excess of EHB to be at no cost to the state if they fill in critical coverage gaps.** We recognize that this would entail careful cost calculations to ensure that additional mandated benefits do not get passed on as cost-sharing to consumers. Nevertheless, we are concerned that QHP benefit packages do not meet the needs of vulnerable populations and that benefit packages still maintain harmful gaps in coverage. For instance, CMS’s recent report shows that CHIP plans in all states are much more affordable and comprehensive for “child-specific” services than plans on the Exchange. If children on CHIP ever have to transition to the Exchange, we are concerned they will lose crucial coverage and cost-sharing protections – begging a discussion of how to make QHP benefit packages both affordable and high value for all consumers.
4. **We urge CMS to take measures to ensure that QHP issuer cost calculations regarding the cost attributable to each additional state-required benefit are accurate (§ 155.170(c)(2)(iii)).** We also recommend that CMS release this data for public stakeholders (consumers, policymakers, researchers, etc.) to better understand the relationship between benefits and the affordability/cost of plans.

§ 155.210 – Navigator Program Standards

1. Overall, we support the proposed changes to require Navigators to provide targeted assistance to serve underserved and/or vulnerable populations within an Exchange service area. We feel that Navigators are uniquely positioned to serve these populations because they are currently required to have expertise in the needs of these populations, and many are from community and consumer-focused nonprofits who have strong ties to and pre-

existing relationships with these communities. As a result, we feel that Navigators are strongly positioned to meet this requirement. However, **we request that CMS further explain how Navigators are expected to “target” or “focus” their work on these populations, since they are also required to assist any consumer seeking assistance.**

In particular, we urge CMS to do the following:

- a. Define what activities or strategies they view as “targeting” a particular population;
 - b. Provide guidance on how Navigators can or should assist other underserved or vulnerable populations as well as all other consumers seeking assistance;
 - c. Provide Navigators the opportunity to give input to the Exchange on which populations or communities they feel should be a target priority, as well as proposing additional populations.
2. We also support CMS’s decision to require Navigators to help consumers with post-enrollment assistance **because we firmly believe that robust and comprehensive enrollment assistance does not stop at enrollment.** Helping consumers gain and maintain effective health coverage requires assisting with post-enrollment needs in addition to the application and plan selection process. Assisters are uniquely positioned to provide post-enrollment assistance because they are often the first point of contact for consumers who have post-enrollment questions, such as how to access care, find a provider, or file an appeal. However, **we are concerned that the regulations as written do not provide enough guidance to Navigators about the type or amount of assistance they’re expected to provide.** While we feel that requiring Navigators to provide information to consumers on post-enrollment is an effective way to ensure consumers are educated, we also feel that Navigators should not be expected to be the experts in these areas, nor should they be held out as the experts in these areas to their communities. Therefore, **we recommend that CMS alter the language of the proposed §155.210(9) to further define what it means by “assistance with” so that Navigators can be clear on the full extent of consumer support expected from CMS in these areas.**
3. **While we support the new requirement for Navigators to provide information and assistance with exemptions, we suggest that Navigators include disclaimer language within the consent form provided to consumers that authorizes Navigators to provide enrollment assistance and gain access to consumers’ personally identifiable information (PII) instead of the proposed oral disclaimer.** We feel that providing consumers with an oral disclaimer that Navigators are not tax advisers and cannot provide tax advice prior to providing any other type of assistance is not the best way to initiate or maintain a strong relationship with a consumer and may cause consumer confusion and adversely affect the enrollment relationship. Including the disclaimer language in the authorization form will allow consumers to be fully informed of the scope of Navigator duties while also allowing Navigators to begin enrollment appointments in their traditional manner and effectively build and maintain relationships with consumers during the appointments.

4. We also support the requirement that Navigators provide information regarding the tax credit reconciliation process **but request further support from CMS in helping Navigators provide the level and type of assistance that is being required of them in the proposed rule.** We agree with CMS that Navigators have expertise related to Exchange eligibility and enrollment rules that uniquely qualify them to help consumers with the reconciliation process. However, we are also aware of the resource limitations that Navigators and their funding agencies may face and are concerned about the amount of time that may be required for Navigators to familiarize themselves with all of the IRS resources available, as well as all of the tax law, legal aid, and VITA agencies that may be available in their area. To better help Navigators meet this new requirement, **we suggest that CMS incorporate new modules regarding tax credit reconciliation and referrals to tax preparation services into the annual assister training and require both new and returning Navigators to complete the modules,** so that Navigators can be provided with a pre-dedicated, mandatory time in which they can build the level of knowledge needed to assist consumers.
5. **We strongly applaud CMS for codifying assistance with health insurance literacy needs as a formal requirement for Navigators.** Our experience on the ground has taught us that consumers often return to assisters with questions regarding how to use their coverage to access care, and formalizing this type of post-enrollment assistance will ensure consumers are able to use and maintain meaningful coverage. Before creating additional health insurance literacy topics for Navigators to be required to provide assistance in, we feel CMS should provide additional information or referrals to resources where assisters can become knowledgeable of health insurance literacy topics. In particular, many of the assisters we work with report that they often contact issuers to obtain information of specific plan benefits, terminology or services. Therefore, **we request that CMS require insurers or agents/brokers to provide information to assisters regarding plan benefits and details to increase Navigators' ability to assist with health insurance literacy.**
6. **We request that CMS update and republish their current regulations and guidance surrounding the use of personally identifiable information (PII) to make clear whether Navigators are permitted to collect, disclose, access, maintain, store and/or use PII to carry out these proposed post-enrollment activities.** We understand that CMS recently updated the model Navigator consent forms to allow consumers to authorize Navigators to use PII to follow up with consumers for certain post-enrollment needs. However, our experience working with assisters has informed us that many Navigators still feel hesitant to maintain any PII after an enrollment appointment other than the authorization form, and many do not keep any PII after an enrollment appointment. Therefore, we request that CMS republish the current guidance so that more Navigators can become aware of it, as well as update the current guidance to make explicit that Navigators can keep and use PII to engage in post-enrollment assistance. We feel that using PII will be a critical component to being able to follow up with consumers and carry out these post-enrollment activities.

7. Lastly, **we strongly urge CMS to invest funding in Consumer Assistance Programs (CAPs) (see 45 CFR 155.205) to assist Navigators in meeting these new requirements.** Because CAPs have been assisting consumers with health insurance literacy and filing appeals for years, CMS should re-engage with these entities and provide funding to them. We feel that supporting CAPs and fostering a relationship between Navigators and CAPs will best ensure Navigators can meet these new requirements.

§155.335 - Annual Eligibility Redetermination

1. **We applaud CMS for considering ways to minimize potential disruptions of enrollee eligibility with continuous enrollment in silver-level plans with cost-sharing reductions, if that plan is no longer available for reenrollment and if the enrollee's current product no longer includes a silver-level plan.** We support reenrolling consumers in a silver-level plan offered by the same issuer in a product that is most similar to the consumer's previous product. We agree with CMS that transitioning enrollees in this manner is an efficient way to reenroll consumers and is also protective of their health needs and financial situations.
2. We share CMS's interest in protecting consumers from being automatically enrolled in plans with substantially higher premiums. However, while we know that low-premium plans are important to many consumers, **we are concerned that defaulting to the lowest cost plan will have negative consequences on network adequacy and market competition.** Because the lowest cost plans often correspond with the narrowest networks on the Marketplace, we are concerned that consumers will opt into this re-enrollment option enticed by the premium implications, and end up with a plan that doesn't have a network of providers to adequately address their needs or with cost-sharing that substantially increases their out-of-pocket costs. **Therefore we recommend that if lowest cost is the primary factor in determining which plan to automatically enroll consumers in, then consumers who opt into automatic enrollment should be assigned to at least the three lowest cost plans in the service area to increase competition. Additionally, we recommend that other factors be considered when determining a reenrollment hierarchy so that consumers can better maintain continuity of care, such as plans with similar provider networks and drug formularies.** For example, machine readable data could be used to identify plans with the most similar provider networks and drug formularies to the consumer's current plan.

Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

§ 156.122 – Prescription Drug Benefits

1. **We applaud CMS for recognizing the importance of medication assisted treatment for substance use disorders, particularly opioid addiction. We strongly believe that it is necessary to ensure access to medication-assisted treatment (MAT) for opioid addictions under the substance use disorder Essential Health Benefit.** Access to MAT where medically indicated is a critical and necessary component of health coverage within the mental health and substance use disorders EHB category. However, we caution that the use of prescription drugs to treat substance use disorders is only one component

of a comprehensive treatment plan that generally also includes counseling and other therapies.¹ Medication coverage alone will continue to fall short of addressing the health needs of this population if the overall benefit package for mental health and substance use disorders is not sufficiently comprehensive.

2. The widespread exclusion of medications used to treat substance use disorders in QHPs is one of many reasons that many QHPs fail to meaningfully comply with the EHB standard. Based on a review of the 2017 state benchmark plan drug formularies, private insurance plans governed by the ACA cover significant numbers of medications to help in the treatment of other chronic illnesses including hypertension, cancer and heart disease. The same review suggested significantly more limited coverage of substance use disorder medications than medications utilized in the treatment of other chronic illnesses. Failure to provide coverage of substance use disorders medications in a comparably comprehensive way to coverage of medications for other chronic diseases suggests a violation of the federal parity law. **We urge CMS to include in the final rule clarifying language that, to comply with the EHB and parity requirements of the ACA, plans must cover all FDA-approved addiction medication.**

§ 156.20 Standardized Options

1. We support a standardized plan option and are pleased CMS is thinking about how to reduce consumers' burden in plan selection. However, **we urge CMS to make standardized plans a requirement for plans offering a QHP in an FFE in 2017.** If standardized plans are optional it may result in limited participation by the insurers, which would have the effect of making the standardized option less meaningful. Other states cited in the proposed rule as examples for the standardized option, like California, Massachusetts, and New York, require insurers to have at least one standardized option on the exchange (and all plans in California are standardized). At a minimum, CMS should design a strong incentive for issuers to offer standardized plans. **We recommend that CMS places standardized plans at the top of the Exchange website and delineates these plans from non-standardized plans in a way that encourages consumers to consider these standardized options.**
2. As proposed, the specialty drug tier for the standard silver plan has a 40% coinsurance responsibility for the enrollee. For individuals with chronic conditions who rely on costly medications for their treatment, a coinsurance of 40% would likely result in consumers rationing medication or forgoing it all together. Therefore, **we urge CMS to adopt a copay, instead of coinsurance, for specialty drugs in standardized plans.** Requiring a copay would increase transparency and better allow a consumer to understand their potential financial liability in a standard plan. In the alternative, **we recommend that CMS lower the coinsurance to at least 20%.** This is currently the cost-sharing amount for the specialty tier in the Covered California standardized benefit design.

¹ Medication Assisted Treatment for Substance Use Disorders Bulletin, July 11, 2014, available at: <http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>

Additionally, we urge CMS to define “specialty tier” so that insurers do not place all expensive drugs in specialty tiers. The specialty tier was initially designed as a way to designate those drugs that required additional assistance (often from pharmacists) with the drug’s administration. Even so, insurers have increasingly assigned this tier to many different drugs, seemingly to discourage usage, or to pass more of the cost of the medication onto consumers.

3. As proposed the standard plans do not offer a benefit design that is standardized across all EHB services. **We urge CMS to add all EHB services to the standard benefit design.** The major categories that are not specified include durable medical equipment, emergency transport, mental/behavioral health inpatient services, substance use disorder inpatient services, habilitative services, maternity care, and children’s dental and vision services. It is misleading for shoppers to label a plan “standardized,” yet to simultaneously have numerous non-standardized elements in each plan. Consumers will be expecting that all aspects of a standard plan to be standardized, which could potentially expose consumers to large out-of-pocket costs in the future. Without accounting for all EHB services, consumers who are trying to compare plans for a service such as maternity care, which is currently not in the standard benefit design, will be unable to use the standard plans to help narrow their options. Additionally, failing to standardize all benefits could allow insurers to set cost-sharing amounts that discourage enrollment by those with certain chronic diseases, particularly because the services not currently standardized will likely be disproportionately used by those with certain health conditions.
4. We applaud CMS for making certain services exempt from the deductible in the proposed standardized benefits. However, **we urge CMS to include outpatient rehabilitative services and laboratory services as exempt from the deductible** as these are commonly used services that are exempt from the deductible in many of the states who have implemented a standardized option. We appreciate that CMS has to balance the overall cost of a standard plan with the number of services that a consumer can access without meeting a deductible

§ 156.230 Network Adequacy Standards

State Selection of Minimum Network Adequacy Standards

1. We believe that the Medicare Advantage standards, with their five geographic categories that account for geographic variations in provider accessibility and population distribution, would serve as an appropriate basis for QHP federal default standards. However, **we recommend that CMS incorporate minimum provider/facility ratios in its standards for QHPs.** In addition, we recommend that CMS supplement the Medicare Advantage standards to account for differences between Medicare plans and QHPs in the covered population and covered services. In particular, **we suggest that CMS incorporate the use of pediatric-specific standards** that would allow for an assessment of provider networks that is based on the inclusion of in-network pediatric providers capable of providing appropriate care from well-baby care to care for children and youth

with special health care needs, including those with serious, chronic or complex conditions.

2. In addition to time and distance standards and provider-to-covered person ratios, **we strongly urge CMS to set maximum appointment wait times for a wide range of services** including primary care, specialty care, urgent care for medical and dental services, urgent care for mental illness and substance use disorders, non-urgent mental and behavioral health services, life-threatening emergency care, and expanded practice access (including same day appointments for urgent needs and after-hours access to clinician advice).
3. Regardless of what quantitative standards are used, **we urge CMS to provide greater scrutiny over the inclusion of specific provider types, particularly hospital-based physicians at participating hospitals.** This is a critical step to protect consumers from balance billing.
4. When determining network adequacy for QHPs that use a tiered network, **we urge CMS to clarify that only providers in the lowest cost-sharing tier will be counted for purposes of determining network adequacy.** Using providers who are assigned to a higher cost-sharing tier can result in significantly more out-of-pocket costs for consumers. Given the significant cost impact, consumers should be able to access all covered benefits through providers in the lowest cost-sharing tier without unreasonable travel or delay.

Additional Network Adequacy Standards

1. We commend CMS for recognizing the need for consumer notification and a transition period when one of their providers is being discontinued from their plan's network. Specifically, CMS proposes requiring QHP issuers in all FFEs to notify enrollees about a discontinuation of an in-network provider as well as ensuring that enrollees have continuity of care protections when a provider is terminated without cause. **In general, we support these important consumer protections but believe they are important enough to warrant applying them to all QHPs, not just those in FFE states.**
2. Allowing enrollees in active treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates in cases where their provider is terminated is an important step to minimize disruptions in care and ensure uninterrupted access to medically necessary services. However, **we believe that the 90-day transition period should be the minimum, rather than the maximum, length of time for patients being treated for a life-threatening condition, a serious acute condition, pregnancy, or another health condition (such as severe depression or a mental health condition) that would be worsened by discontinuing care by the treating health care provider.** More specifically we recommend:
 - a. Patients who have been diagnosed with a terminal illness, defined as a disease or condition that cannot be cured or adequately treated and that is reasonably expected to result in the death of the patient within six months, be allowed to

continue with their provider until the end-of-life, even though this may extend beyond 90 days.

- b. Providing a continuity of care transition period for new QHP enrollees, as CMS has previously encouraged QHP issuers to permit. Specifically, new enrollees in the midst of an active course of treatment should be able to continue that treatment with their current providers for up to 90 days, even if those providers are not in their new plan's network.
3. **We strongly support allowing care for women in their second or third trimester of pregnancy to be extended through the post-partum period**, commonly defined as the six weeks after birth, even though this may be longer than 90 days.
4. We appreciate CMS's effort to put in place a provision to limit surprise bills to enrollees by requiring issuers to count the cost sharing charged to the enrollee for certain out of network services provided at an in network facility towards the enrollee's annual limitation on cost sharing. However, **we believe that this is an inadequate protection especially when issuers can avoid their responsibility by providing written notification to enrollees 10 days in advance that additional costs for an out of network service might be incurred.** To reduce the financial burden enrollees and/or their families might face at a time when they are most vulnerable dealing with sickness, **we strongly urge CMS to adopt stronger requirements to protect enrollees from unexpected balance billing by out of network providers.** We strongly believe that enrollees should be protected from and should not be subject to out of network cost sharing in cases when they could not be reasonably expected to know or control whether care are being delivered by out of network providers. These situations include, but are not limited to:
 - a. Unavailability of in-network providers for a covered EHB service;
 - b. Unexpected utilization of out-of-network care at an in-network facility for a covered EHB service;
 - c. Emergency care;
 - d. Out of network care as a result of an inaccurate provider directory.

In addition, any charges from out of network care as described in the above situations should count toward an individual's maximum out-of-pocket limit.

§ 156.235 – Essential Community Providers

1. We have concern that the proposed changes to credit issuers for each FTE at an essential community provider (ECP) location towards satisfaction of the ECP standard (and towards the total count of available ECPs in an area) will lead to diminished access to ECPs in qualified health plans (QHP) networks. We understand the intent of this proposal is to more accurately reflect the ECP's capacity to deliver care, but we think there are a number of reasons for which this proposal will hamper access to care for low-income, underserved populations, as well as be impossible to implement in a simple and accurate manner:

- a. Geographic distribution concerns: By counting each FTE in an ECP as its own ECP, it would be much easier for issuers to meet the ECP requirements while only contracting with ECPs in limited geographic locations within their service area. We worry that under the proposed change insurers would be able to contract with only or primarily the ECP facilities (and their providers) in the more affluent areas that include a more desirable population to serve yet still be able to meet the ECP standards. We believe that issuers only including ECPs in a few or even only one area within their service area would undermine the intention of including ECPs in-network, which is to offer provider options for populations that have often unmet needs, such as populations in underserved, low-income areas, rural areas, etc
- b. Concerns about distribution of provider types: Examining the FTEs of providers in an ECP provides no information about what types of providers are employed by the ECP. There is no information about whether the providers in the count are physicians, nurses, specialty physicians, etc. and therefore no sense of whether insurers would be able to deliver a comprehensive array of covered benefits to low-income, underserved enrollees even if they met the ECP standard under a standard where each FTE counted as its own ECP. By counting each ECP facility as a single ECP, there is a much stronger guarantee that low-income, underserved consumers will have comprehensive in-network access to a full range of covered benefits.
- c. Concerns about distribution of ECP types: QHP issuers must currently offer contracts to all Indian health providers in their service areas, as well as to at least one ECP in each county in their service area (where available) in each of five other ECP categories. Offering a contract doesn't guarantee that ECPs will ultimately be in-network. Therefore, with no specific requirements to have a range of different ECP types in network, combined with a proposal to count each ECP FTE employee as an individual ECP (thereby potentially including the number of ECP facilities included network), there is a potential to reduce the range of ECP types included in a plan's network.
- d. Concerns about including out-of-network providers: As is the case with most health care facilities, although an ECP facility is in-network with a health plan, not all providers in that facility necessarily have contracts with the same insurance plans as does the ECP facility. Therefore, it is inaccurate and should not be the practice under the Benefit and Payment Parameter rule to automatically count all FTE practitioners in an ECP facility as accessible to a QHP enrollee simply because the ECP facility is in-network for that enrollee. Furthermore, ECPs have described the credentialing process with a health plan for an ECP practitioner as a long and laborious process, so assuming that an ECP practitioner is credentialed by a health plan that has a contract with an ECP is also inaccurate.
- e. Failure to recognize mid-year changes: Some ECPs rely on providers who practice in many locations or who have multiple jobs. Therefore, throughout the year an ECP's cadre of providers changes. Many ECPs have expressed this experience to Families USA and therefore they are concerned that counting each FTE as a single ECP will

not accurately reflect the availability of ECPs for QHP enrollees because the size of ECP staff changes regularly and therefore counting each ECP facility as one ECP is a much more accurate way to assess availability of ECPs in an area.

We recommend CMS should leave intact for future plan years standards that count each ECP facility as a single ECP. Each contracted full-time equivalent practitioner at a single ECP location should not be counted as an individual ECP, including for health plans that qualify for the alternate ECP standard under 156.235(a)(5). ECP standards should be set to ensure that ECPs included in-network are appropriately distributed across the geography of a plan's service area with a special emphasis on including ECPs in the lowest-income and most medically underserved areas of the service area. ECP standards should only allow insurers to count entities that they can document are contracted with their plan towards meeting the ECP standard.

2. The preamble to the rule states that CMS will not disaggregate ECP categories to ensure better access to a wider variety of health care services for QHP enrollees. By grouping together providers such as Hemophilia Treatment Centers, Community Mental Health Centers, and Rural Health Clinics into one ECP category such that issuers are only required to offer a contract to one of these and other types of providers in a given county, CMS runs the risk that low-income, underserved enrollees will have inadequate access to key providers that are uniquely suited to meet their specialized health needs. We therefore believe that the **ECP categories must be modified to separate the distinct entities in such categories and require contracting with each of them.** We believe that to not disaggregate these categories *and* to count each ECP FTE practitioner as a single ECP would significantly hinder access to ECPs for low-income, medically underserved QHP enrollees.

Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirements

§ 158.103 and 158.140(a) - Reporting of Incurred Claims

1. **We do not recommend that CMS include fraud and abuse in the MLR calculations as long as the amount excluded does not exceed 0.5 percent of premium.** We understand CMS's desire to support prevention of fraud and abuse, and we agree that this is a priority for all Exchanges. Health insurance issuers should be aggressive about fraud and abuse; however, issuers should conduct such fraud and abuse prevention activities as part of their everyday operations.

Plans are supposed to select their providers carefully and they are expected to not engage in fraud and abuse. To the extent that any providers (or plans) have historically engaged in such activities, correcting it is a “cost of doing business” that should not detract from the value promised to plan enrollees. We do not believe such administrative expenses should be included in the numerator (or deducted from the denominator). We also note that it would be administratively challenging, if not impossible, to distinguish

administrative activities related to fraud prevention (for example, a review of outlier claims for fraud review purposes) from other administrative activities. If it is retained in the final rule, we recommend maintaining the cap of 0.5 percent of premium revenue. Expenses claimed here should show results over time or be disallowed.

Thank you for this opportunity to comment,
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