January 12, 2015

The Honorable Sylvia Burwell
Secretary
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

Submitted electronically to FFComments@cms.hhs.gov.

Re: Draft 2016 Letter to Issuers in the Federally-Facilitated Marketplace

The National Health Council (NHC) appreciates the opportunity to submit comments on the draft letter to issuers in the federally-facilitated marketplace for the 2016 plan year. We are writing this letter to offer support for requirements that improve the patient friendliness of the marketplace and raise concern about other rules that leave patients without adequate protection.

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 as well as 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 groups, which control its governance. Other members include professional societies and membership associations, nonprofit organizations with an interest in health, and major pharmaceutical, medical device, biotechnology, and health insurance companies.

While we applaud the Department of Health and Human Services (HHS) for increasing several network adequacy and patient protection standards from last year, we believe that it is important to increase the issuer requirements further to protect vulnerable patient populations, particularly those living with chronic diseases and conditions. Our comments are organized according to the following sections of the letter:

- Chapter 2
  - Section 3: Network Adequacy
  - Section 9: Essential Health Benefits Discriminatory Benefit Design
- Chapter 6
  - Section 1: Consumer Case Tracking and Resolution
  - Section 4: Summary of Benefits and Coverage
We strongly believe that this letter to issuers continues to move the needle towards better patient protections in exchange plans. This letter to issuers, together with many of the provisions in the proposed rule on the 2016 Notice of Benefits and Payment Parameters, will undoubtedly strengthen patient protections in the market if both guidance documents are finalized as written. Even so, the NHC remains concerned about certain elements of the draft letter to issuers. Below we outline our support for certain provisions and discuss changes to the proposed rule that will help to ensure that patients have access to health coverage that addresses their medical needs at the most affordable price in 2016.

Chapter 2, Section 3: Network Requirements Are an Improvement But Require Refinement

As noted in the issuer letter, issuers will be required to submit a provider list that includes all providers, facilities, and pharmacies in the plan’s network for the 2016 plan year. The Centers for Medicare and Medicaid Services (CMS) will review the list to evaluate provider networks using a “reasonable access” standard. We believe it is important for HHS to have more stringent requirements to review network adequacy. One example of increased network review would be to expand the list of providers of particular attention. The current list of five groups highlighted in the draft letter—hospitals, mental health providers, oncology providers, primary care providers, and dental providers, when applicable—does not adequately capture the spectrum of network concerns patients and the general public have. CMS also should review whether the network list includes a satisfactory number of providers accepting new patients. Further, CMS should issue further guidance regarding how the agency defines and screens for “reasonable access.” Guidance defining the bounds of “reasonable access” would have important implications for patients who need to have ready access to in-network providers.

Finally, the NHC submitted more extensive feedback on the network adequacy requirements included in the Notice of Benefits and Payment Parameters for 2016 proposed rule.1 We reiterate those comments here, including our support of requiring direct links to provider directories that are updated at least monthly and in an HHS-designated template.

Chapter 2, Section 9: Reviews for Essential Health Benefits and Qualified Health Plan Discriminatory Benefit Design Should Be Improved

The NHC appreciates that the ACAs prohibits plans from discrimination against any category of people or enrollees. As the agency acknowledges, this proposed draft letter and current regulations do not go far enough to ensure adequate protections against discrimination. NHC recommends that CMS consider expanding upon the proposed policies for 2016, to better meet the needs of patients, especially those with chronic and/or high-cost health care needs in the following ways: further define anti-discrimination, increase formulary transparency requirement, and create a uniform medical necessity definition.

Though the NHC appreciates that states and health plans are required by the ACA to ensure that benefits do not discriminate against any category of people or enrollees, the NHC would encourage CMS to include in its forthcoming final issuer letter the following provisions:

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Implement more detailed processes for review of plan benefits design to avoid discrimination caused by unfair plan design elements, including utilization management techniques, the structure of the formulary (e.g., use of specialty tiers), and cost sharing requirements across all benefits.

- Perform additional reviews, beyond an outlier test, of Qualified Health Plans and Benefits Templates. Outlier tests can be useful when discriminatory benefit design is the exception, rather than the rule. They are less valuable when discriminatory benefit designs are more commonplace among plans.
- Perform additional reviews, beyond an outlier test, of plan cost-sharing. As noted above, outlier tests can prevent discriminatory cost sharing only when the discriminatory behavior is the exception to the rule. Common practices, such as higher cost sharing for certain medications and/or treatments, may not be identified in an outlier analysis. Such practices discourage individuals with one or more chronic conditions from enrolling and thus are clearly discriminatory. Reviews of cost sharing should be thorough enough to ensure that such practices do not occur in federally-facilitated marketplaces.

Establish final authority at the federal level to approve any state non-discrimination review processes to ensure appropriate measures are in place to guarantee that plans are meeting the requirements of this section.

Develop and implement federal monitoring programs to ensure appropriate checks are in place to guarantee that plans are meeting federal requirements.2

For more details on non-discrimination standards, please see the NHC’s proposed regulatory language for a model comprehensive set of patient protections.3 Additional details on prohibiting specialty tiers and ensuring non-discriminatory cost-sharing practices is also available.4

Chapter 2, Section 10: Prescription Drug Reviews and Oversight May Not Achieve Non-discrimination

The NHC appreciates the proposed requirement, both here and in the draft payment notice, that formularies must be easily accessible—without requiring the creation of an account or other patient hurdles—and machine readable. However, we continue to argue that plans should be required to list all of their covered medications on a single formulary. Currently, some plans have multiple formulary documents for circumstances including the standard formulary, formulary updates, specialty medications covered, medical benefit coverage, etc. We encourage the agency to consider methods to make formularies available in a standardized template that could be used, in the future, for a “plan finder” type tool on healthcare.gov. Additionally, we strongly support the requirement that tier placement and utilization management details be included in the formulary. Further, the data collected from plans and used on enrollment portals should accurately reflect formulary structure. Currently healthcare.gov is designed to show only four tiers of drug cost-sharing, even for plans with five or more formulary tiers. Consumers must open the summary of benefits and coverage to understand actual formulary structure and costs, without any indication that a plan has more than four tiers.

In this proposed letter to issuers, CMS outlines two net new drug reviews during 2016 Qualified Health Plan certification: a formulary outlier review and a clinical appropriateness review. While these reviews are a good first step to better federal oversight of Qualified Health Plan formularies, substantial gaps remain. First, as discussed earlier in this comment letter, outlier tests are only effective when the predominance of plans are in compliance. With reviews of plan formularies showing a substantial portion of plans designing formularies in ways that discriminate against major chronic conditions, there is extreme concern that an outlier test lacks relevance and effectiveness here. Further, the clinical appropriateness review is limited to only four conditions—bipolar disorder, diabetes, rheumatoid arthritis, and schizophrenia. Though this review, in particular, will be helpful to patients with these four conditions, there remains a great number of conditions where there is clinical concern for the adequate formularies—multiple sclerosis, cancer, and HIV/AIDS, to name a few.

Finally, the NHC submitted more extensive feedback on the formulary requirements included in the Notice of Benefits and Payment Parameters proposed rule.5 We reiterate those comments here, including our support of requiring direct links to formularies in a HHS-designated template and our concern over the reliance on pharmacy and therapeutics committees to ensure adequate access to medications.

Chapter 2, Section 13: Reviews of Cost-Sharing Reduction Plans Are Appropriate But Could Be Enhanced

The NHC agrees that reviews of cost-sharing reduction plans are appropriate to ensure that people who qualify for lower cost sharing are, in fact, accessing plans with reduced costs. Additionally, HHS should review all cost-sharing reduction plans’ cost-sharing requirements across the entire spectrum of services that are more than 10 percentage points higher than the qualified health plan’s actuarial value would require (for example, 40% coinsurance in a silver plan with a 86% actuarial value). A study released earlier this year examined the percent of silver plan variations that reduce cost sharing for key services and determined that many of these variations, for 2014, do not reduce cost sharing for key services, such as specialist care or brand medications. This trend was even prevalent for 94% actuarial value variations. About half of these 94% actuarial value plans did not reduce cost sharing for fourth-tier medications from the standard silver cost sharing.6 With such flexibility awarded to plan issuers to design silver plan variations, it is likely that this trend will continue. The data in this analysis indicate that such variations discriminate against patients who need expensive or specialty medications.

Chapter 6, Section 1: Consumer Case Tracking and Resolution Requirements Are Critical

As patients are enrolled and utilize their coverage in the exchanges, it is vital to have a functioning, effective system to support patients when issues occur. The NHC supports the case tracking and resolution system, as described in the draft issuer letter. One important improvement would include requirements that issuers, states, and the federal government make more prominent the contact information for the customer service process for each of these entities. This would include making it clear to consumers whether the general contact information for an issuer, state, or healthcare.gov is the place to report cases when they arise.

Chapter 6, Section 4: Summary of Benefits and Coverage Requirements Help Patients Access Important Information

The NHC supports the requirement that health plans provide summary of benefits and coverage documents that accurately represent the cost-sharing reductions available to individuals and families with limited income through silver plan variations. We recommend that summaries be standardized and machine readable.

As the voice for those with chronic diseases and disabilities, NHC believes that broad patient protections are critical to the success of qualified health plans and exchanges. As HHS finalizes the notice of benefit and payment parameters for 2016, the NHC strongly encourages the agency to include in its final regulations the above-referenced levels of patient protections supported in our previous communications with the agency.

Please do not hesitate to contact Eric Gascho, our Assistant 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. You may also reach me on my direct, private line at 202-973-0546 or via e-mail at mweinberg@nhcouncil.org.

Sincerely,

Myrl Weinberg, FASAE, CAE
Chief Executive Officer