National Health Council

1730 M Street NW, Suite 500, Washington, DC 20036-4561 ■ 202-785-3910 ■ www.nationalhealthcouncil.org ■ info@nhcouncil.org

BOARD OF DIRECTORS

Chairperson
Randy Beranek
National Psoriasis Foundation

Chairperson-Elect
Tracy Smith Hart
Osteogenesis Imperfecta Foundation

Vice Chairperson
Cynthia Zagieboylo
National Multiple Sclerosis Society

Secretary
James C. Greenwood
Biotechnology Industry Organization

Treasurer
Elizabeth J. Fowler, PhD, JD
Johnson & Johnson

Immediate Past Chairperson
Nancy Brown
American Heart Association

Margaret Anderson
FasterCures –
A Center of the Milken Institute

Marcia Boyle
Immune Deficiency Foundation

John Castellani
PhRMA

Barbara Collura
RESOLVE: The National
Infertility Association

Robert Gebbia
American Foundation for
Suicide Prevention

Eric Hargis
Colon Cancer Alliance

Dan Leonard
National Pharmaceutical Council

Barbara Newhouse
ALS Association

Ann Palmer
Arthritis Foundation

Paul Pomerantz, FASAE, CAE
American Society of Anesthesiologists

Eric Racine, PharmD
Sanofi

Michael Rosenblatt, MD
Merck

J. Donald Schumacher, PsyD
National Hospice and
Palliative Care Organization

Steven Taylor
Sjögren's Syndrome Foundation

John W. Walsh
Alpha-1 Foundation

Ex Officio Member
Marc Boutin
Chief Executive Officer
National Health Council

December 21, 2015

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 2017

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 2017 (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 societies and membership associations, nonprofit organizations with an interest in health, and major pharmaceutical, medical device, biotechnology, and insurance companies.

We strongly believe that many of the changes included in this proposed rule will benefit people with chronic diseases and disabilities.

However, the NHC remains concerned about HHS's lack of specificity related to the elimination of plan design elements such as drug tiering and other cost-sharing mechanisms that discriminate against people with chronic conditions.

We urge you to create patient safeguards to prevent discriminatory plan designs by more thoroughly addressing in the final rule or future rulemaking plan cost-sharing structures, transparency standards, uniformity of content and design, and continuity of care requirements, and by ensuring all health exchange plans meet federal requirements.

Over the past few years, the NHC has focused its ACA-related advocacy efforts on patient protections that would ensure the health insurance

marketplaces are ideal settings for all individuals and families, including people with chronic conditions. Below we outline our support for certain provisions of the NBPP and discuss changes to the proposed rule that will help to ensure that patients obtain and retain the right coverage that meets their health care needs and budget in 2017.

Ensure cost-sharing structures and other plan design elements do not discriminate against people with chronic conditions and impede access to care

As previously stated, the NHC believes that HHS missed an opportunity to adequately address discriminatory plan designs through this rule, and we urge you to holistically address this issue in future rulemaking. With that said, we do believe there are provisions contained in this rule that will ensure plans better meet the needs of people with chronic conditions.

Minimum Thresholds for Network Adequacy (§156.230(D))

The NHC supports the concept that states are responsible for the oversight of exchange plan networks in operation in their jurisdictions. We also support the approach HHS described in this proposed rule that would set bounds for states in developing oversight protocols for networks. This would require states to select an acceptable, quantifiable network adequacy metric, subject to certain minimum criteria established by HHS. We also appreciate that this proposal would offer solutions for states that do not conduct reviews. In these states, a federal, default time and distance standard would be used. While federal default time and distance standards should protect against unacceptably narrow network offerings, we believe that the individual states should first review the networks offered in their state. Federal standards and oversight should be used as a secondary protection. We encourage HHS to define state oversight of network adequacy and require strict state oversight as a first line of defense.

HHS should also develop a tightly defined role in enforcement to discourage narrow network offerings altogether. We understand that for the certification cycle for plan year 2017, HHS intends to review the number and types of providers at the county level, using standards similar to those in Medicare Advantage and focusing on the specialties most-commonly used by enrollees. This marks an important development that we hope HHS will build upon. The county-specific time and distance parameters to be detailed in the Letter to Issuers promise to be an important safeguard for patient access.

Further, the NHC believes that adding wait times to network standards, surveying providers to determine if they are accepting new patients, and requiring issuers to be more transparent about their provider networks would improve consumer decision-making, provided HHS and states can appropriately integrate these factors into the standards and oversight procedures.

Acceptance of Certain Third-Party Payments (§156.1250)

The NHC is pleased that HHS aims to clarify which entities may administer premium and cost-sharing assistance through grantees or sub-grantees. HHS' proposal to require issuers to accept third-party cost-sharing payments in addition to premium payments will allow consumers more

flexibility and should alleviate financial pressure in many cases. HHS has taken a step in the right direction by applying these new requirements to entities from which issuers currently accept premium payments, such as the Ryan White HIV/AIDS Programs.

We urge HHS to require qualified health plans (QHPs) to accept third-party payments outright from all non-profit charities. Though the "guardrails" discussed by HHS could be important to mitigate a negative impact on risk pools, the NHC is concerned that limiting assistance to individuals not eligible for other minimum essential coverage (MEC) and requiring financial assistance could result in certain patient populations being excluded. We hope that HHS will not impose guardrails that would take away choices from any chronic disease population.

Create transparency standards to ensure patients have access to complete details about coverage and cost of health insurance exchange plans

Standards Applicable to Navigators and Non-Navigator Assistance Personnel (§155.210; §155.215; §155.225)

The NHC is pleased with HHS' proposal to require navigators in all exchanges to provide targeted assistance to underserved and/or vulnerable populations within an exchange's service area. The service provided by the exchanges has greatly improved since their launch, but remains complex and challenging for many. Patient populations managing multiple conditions may have an idea of what appropriate coverage looks like, but struggle to find a suitable plan. Navigators, if properly trained and if conflicts of interest are appropriately managed, should facilitate a more efficiently operated exchange. If more individuals choose the right plan each year, they will gain access to providers, be subject to lower out-of-pocket costs, and have access to essential medications. Further, the proposal to expand duties of navigators to include specific post-enrollment and other assistance activities may encourage an ongoing dialogue, gradually improving consumer literacy and navigator services. As HHS continues to define the role of navigators, the NHC hopes it will also continue to improve its oversight of them to ensure they remain free of any conflict of interest.

Out-of-Network Cost Sharing (§156.230 (F))

HHS' proposal to require QHP issuers to count cost sharing for an essential health benefit (EHB) by an out-of-network provider in an in-network setting towards the enrollee's maximum out-of-pocket limit has the potential to financially protect enrollees and would encourage greater transparency related to provider networks.

However, we seek greater clarity regarding the term "cost sharing." It is unclear whether this provision would apply to all charges that a beneficiary would face as a result of utilizing the services of an out-of-network provider, whether they are increased copayments or the full costs of services. We urge HHS to clarify this to say that all payments for out-of-network services in an in-network facility must count toward the out-of-pocket maximum.

Further, we are concerned about the NBPP's alternative approach of allowing plans to notify enrollees more than ten days in advance of a potentially out-of-network service. This would be nearly impossible for a plan to predict and also would potentially allow plans to issue general statements in standard plan materials as a means for such notification.

Make insurance exchange plan materials easier for patients to understand by creating uniformity of content and design

Optional Standardized Benefit Design (§156.20)

In general, the NHC is encouraged by the concept of standardized options, which consist of standardized cost sharing for a key set of EHBs in the individual federally facilitated exchanges (FFEs). Standardized benefit designs should simplify the consumer shopping experience and result in more enrollees with transparent and appropriate coverage. Based on our research, without assistance, most people struggle to choose a health insurance plan that meets their needs and simply choose plans with the lowest premiums.[1] Standardizing cost sharing across health plans is one option to simplify these choices. For this reason, we have generally supported states' efforts to require standard options.

Many of the design elements of the standard options in the NBPP, however, are alarming. While many of the elements of the designs in these proposed plans represent an improvement over the status quo (e.g., services available before the deductible, more copayments than coinsurance), the proposed standard benefits are expensive compared to plan offerings available currently through the marketplace. They are also more expensive than the standardized benefits in the state-based exchanges that require standardization. Specifically, deductibles in these standardized plans are mostly higher than average deductibles in the marketplace, and cost sharing for drugs placed on the specialty tier is exceptionally high.

These benefits, while designed to limit costs for healthier enrollees, shift out-of-pocket expenses to the most vulnerable enrollees and limit the value of these plans for these individuals. We believe that enactment of these structures may normalize high cost sharing — limiting access and opening the door to discriminatory practices such as adverse tiering of drugs in traditionally expensive therapeutic areas.

Establish continuity of care requirements that protect patients transitioning into new coverage

Provider Transitions (§156.230(E)) and Individual Exchange Coverage Effectuation and Grace Period (§156.270)

The two new requirements for provider network changes proposed by HHS will improve access to care for patients enrolled in exchange plans. We urge HHS to finalize its proposal requiring all

[1] National Health Council and Lake Research Partners. Measuring the Patient Experience in Exchanges. Available at: http://www.nationalhealthcouncil.org/sites/default/files/NHC-LakeResearch--Patient_Exchange_Experience.pdf .

QHP issuers in FFEs to notify enrollees 30 days prior to discontinuation of a provider and, if a provider is terminated without cause, requiring QHP issuers to allow patients to continue alternative active treatment for 90 days at in-network cost. These provisions, while simple in scope, will protect vulnerable populations in need of daily care by ensuring they flexibly transfer to new providers as their coverage shifts. The process of finding an appropriate physician can take time. The NHC strongly believes that these individuals should not be punished for changes that are well outside their control.

Further, we hope that HHS will finalize its proposal to allow individuals to remain in coverage and receive a three-month grace period if they fail to pay the January premium in full. We certainly understand the importance premiums play in the financial stability of the exchange market, but hope that HHS will allow this leniency. As the exchanges continue to grow and improve, we should allow individuals every opportunity to obtain and utilize coverage within reason.

Ensure that all health insurance exchange plans meet federal requirements

Bases and Process for Imposing Civil Money Penalties in Federally-Facilitated Exchanges; Bases and Process for Decertification of a QHP Offered by an Issuer Through a Federally-Facilitated Exchange; and Plan Suppression (§156.805; §156.810; §156.815)

This proposed rule introduces a meaningful change by HHS by moving away from its previously limited enforcement to a more active role in oversight. In particular, we are pleased that HHS has proposed new standards for decertification to address situations where a QHP issuer is the subject of a pending or existing state enforcement action, including a consent order, or where HHS has reasonably determined that an issuer lacks the funds to continue providing coverage to its consumers for the remainder of the plan year. We believe this marks an important shift in federal oversight of the exchanges and hope that HHS will not only finalize this set of provisions, but also further strengthen the federal government's oversight role.

More stringent federal oversight can help to protect patients with complex health needs from discriminatory practices seen in the market, including adverse tiering for medications and exorbitant deductibles. HHS is uniquely suited to oversee the marketplace and state-based exchanges as it has a view into plans across all states in addition to the fact that the ACA squarely places the agency in this oversight role. The NHC acknowledges and appreciates HHS' willingness to engage on issues of patient protection and hopes to continue the dialogue as the exchanges continue to evolve.

Establishment of Patient Safety Standards for QHP Issuers (§156.1110)

HHS' proposed new specifications to strengthen patient safety standards are critically important to the patient community. The NHC believes HHS should codify its proposal requiring issuers that contract with hospitals with 50 or more beds to verify the hospital uses a patient safety evaluation system. Complex health systems need to be organized in such a way that quality of care and patient safety are assured through established and proven protocols. Further, we are

pleased that HHS has taken steps toward ensuring hospitals have comprehensive discharge programs and implement evidence-based initiatives to reduce all cause preventable harms, prevent readmission, improve care coordination, and improve quality. We understand these provisions may be burdensome for hospitals as they begin to implement these requirements. But, we also strongly believe these protections will ultimately improve patient safety and reduce readmissions and other medical costs down the line.

As the united voice for people with chronic diseases and disabilities, the NHC believes that broad patient protections in the redetermination and eligibility process are critical to the success of qualified health plans and exchanges. As HHS finalizes the notice of benefit and payment parameters for 2017, 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 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