American Cancer Society ☙ Children's Defense Fund-New York ☙ Community Service Society of New York
Empire Justice Center ☙ Institute for Puerto Rican and Hispanic Elderly
Make the Road New York ☙ Medicare Rights Center
Metro New York Health Care for All Campaign ☙ New Yorkers for Accessible Health Coverage ☙
New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ☙ Schuyler Center for Analysis and Advocacy ☙ Small Business Majority

December 22, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9944-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-9944-P - Proposed rules regarding the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016

Dear Sir/Madam:

Health Care For All New York (HCFANY), a coalition of more than 160 organizations dedicated to securing affordable, quality health coverage for all New Yorkers, appreciates the opportunity to submit comments to the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) in response to the proposed Notice of Benefit and Payment Parameters for 2016 released November 26, 2014.

The proposed regulations include many important steps forward for consumers. HCFANY applauds HHS for strengthening consumer protections in the proposed regulations, especially in revisiting benchmark plan choices, rate review, and network adequacy standards, and in increasing transparency and data collection overall. In addition, there are a number of areas in which the regulations could be further improved to support consumer access to high quality health care. Our comments highlight advancements for consumers, as well as areas where the regulations could still be strengthened.

Definitions (§ 144.103)

HCFANY generally supports CMS's proposed definition of a "plan" as having a "particular cost-sharing structure, provider network, and service area" (§ 144.103, § 154.102, and section III.A.1.a of the preamble). Regulators undertaking rate review can gain a more accurate picture of the benefits and costs for consumers by reviewing health insurance according to these features, rather than considering rate increases at the product level.

However, HCFANY urges CMS to issue guidance regarding when a modified plan should be considered the same plan for the purposes of rate review. HCFANY has strong concerns that without such guidance, insurance companies could effectively avoid the rate review process by issuing a "new" plan that is essentially an existing plan with minor changes to cost-sharing, provider network, or service area. CMS should safeguard against this practice by adopting the product-level uniform modification of coverage standard as a plan-level standard for the purposes of rate review (§ 147.106(e)). Further, CMS should issue guidance directing states to look across all standards and use judgment about when a plan's changes to cost-sharing, provider network, or service area warrant its consideration as a new plan. Only a substantially different plan design should be recognized as a new plan for the purposes of rate review, in order to keep vital consumer protections in place.

Rate Review (Part 154)

HCFANY generally supports the proposals related to rate review, which would increase transparency and establish more uniform timelines for rate review processes. We particularly support CMS's proposal to require the state or CMS to consider rate increases at the plan level instead of the product level when determining whether an increase is subject to a review. This proposed change is an important step to protect consumers from unreasonable rate increases, as consumers are most affected by rate increases at the plan level. However, CMS should provide states with guidance on how to assess modified plans for the purposes of rate review, as described above.

HCFANY also supports CMS's proposal to establish a uniform timeline for all states with regard to insurer rate filings (§ 154.220). Establishing a uniform timeline will increase transparency and, while dependent on state adherence to the timeline, add a level of predictability that will help to increase awareness about the rate review process and public comment periods.

However, while HCFANY applauds CMS's proposal to increase transparency requirements for effective rate review states (§ 154.301), we recommend that CMS also require a sixty-day comment period on proposed rate increases. To support public comment, we recommend that effective rate review programs be required to do the following, which are exhibited in New York State's rate review program and those of certain other states:

- The complete filing – Parts I, II and III of the insurer filing should be made available on the State's website.
- The State's website should clearly specify how consumers can comment on the filing, how to obtain the filing, all relevant deadlines, and where to go for help.
- Consumers currently enrolled in the plan should receive a notice from the issuer about the proposed increase (or decrease) at the time of filing and any plan design changes, along with instructions on how to comment.
- The State website should make clear what happens to comments that have been filed, the resolution of the requested rate increase, and how to request additional information or file a complaint.

Further, HCFANY urges CMS to install additional requirements for Part III of the Rate Review Justification (Actuarial Memorandum) to promote greater standardization, including:

- Narrative justifications of rate increases should include detailed descriptions of how insurers arrived at assumptions, such as trend factor; changes in administrative costs; and changes in provider compensation arrangements. Issuers should be required to disclose executive compensation as part of administrative costs.
- Issuers should be held to a standard for estimating receipts from or payments to risk adjustment pools, and to state the basis for their estimates.
- Issuers should be required to disclose the anticipated effect on reserves and justification for reserve amounts.

This standardization is important to enable States, consumers, and advocates to comprehend rate increase requests and evaluate their reasonableness.

Finally, HCFANY recommends that final rate increases should be made available at least 15 days prior to the start of the annual open enrollment period, rather than by open enrollment as suggested in the preamble. 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.

Meaningful Access (§ 155.205, § 156.250)

HCFANY supports the proposals related to meaningful access that will increase accessibility for people with limited English proficiency or disabilities. First, we support the proposed requirement that Exchanges, web brokers, and QHPs offer telephonic oral interpretation services in at least 150 languages. This requirement is particularly important for QHPs, as much of the communication for the enrollee regarding his/her insurance is with the health plan provider and not with an Exchange. HCFANY agrees that this requirement should be limited to Exchanges, web brokers and QHPs, as many community-based Navigator organizations may not have the capacity to meet the standard, though they are likely to reflect deeper cultural expertise with regard to particular underserved communities. The ability of smaller organizations to meaningfully participate in enrollment should not be jeopardized by regulations designed for better resourced institutions.

Second, HCFANY strongly supports requiring that QHP issuers make accessible all information critical for obtaining health insurance or accessing services (i.e. all applications, forms and notices required by law), by providing: (1) auxiliary aids and services to people with disabilities; (2) oral interpretation in at least 150 languages; (3) written translations; and (4) taglines in non-English languages indicating the availability of language services (§ 155.205(c)). Further, HCFANY recommends strengthening accessibility standards in § 155.205(c) in the following ways:

- Require written translations in the languages spoken by the applicable State's top ten Limited English Proficiency (LEP) groups or spoken by 10,000 persons or greater.

- Require taglines in the top 30 non-English languages spoken nationwide, ideally on the same piece of paper as the notice, application, or form, rather than on an envelope. To date, notices in New York have only been in English and Spanish.

Annual Eligibility Redetermination (§ 155.335)

HCFANY is concerned that CMS's proposal to default consumers into the lowest-cost plan, described in the preamble, will negatively impact network adequacy and will be difficult to explain to consumers. Because lowest-cost plans often correspond with narrower networks on the Marketplace, re-enrolling a consumer into a lower-cost plan may compromise their access to essential providers. Consumers may also be faced with higher cost-sharing for provider visits or prescriptions. These additional costs could eliminate a consumer's savings from a lower premium, or, in the case of someone with high medical needs, could dramatically increase their yearly costs. HCFANY would support a more nuanced approach that takes into account cost savings while maintaining a roughly equivalent network. In either case, HCFANY urges CMS to include at least a 30-day grace period to switch plans if a consumer finds that the plan is not adequate to meet their health needs.

Additionally, the proposed automatic re-enrollment strategy would be difficult to explain to consumers. If CMS were to take this approach, consumers would need to be informed about how their re-enrollment choices might impact their coverage. HCFANY urges CMS to consider the following:

- During open enrollment when a consumer has the option to opt into a re-enrollment hierarchy, they should receive notice of what each option means in terms of the potential for higher out-of-pocket costs and changes to provider networks.
- When Marketplace and issuer notices are issued with instructions for upcoming renewal and open enrollment deadlines, the consumer should be notified of which hierarchy they chose during open enrollment and how that default re-enrollment plan differs from their current plan.
- All notices should make clear that the consumer has the option to change plans during the open enrollment period with instructions on how to do so.

Finally, we recommend that CMS continue to make improvements to the current re-enrollment process in place for the 2015 plan year. In particular, we urge CMS to update eligibility determinations for individuals who choose to automatically renew their plans. This will ensure that consumers are receiving the correct amount of financial assistance, and will alleviate the concern that an individual is automatically renewed into a plan with a premium that they are unable to afford. Specifically, we urge CMS to allow states, such as New York, to use verified, recently updated income information provided by the consumer, rather than requiring states to rely on 2013 tax information.

Open Enrollment Period (§ 155.410)

HCFANY agrees with CMS that an open enrollment period that does not cross calendar years will be less confusing for consumers. However, the proposed open enrollment period of October 1 to December 15 for years 2016 and beyond is too short, and the timing is particularly difficult for consumers. Ideally, the open enrollment period would occur during the first part of the year, when consumers are likely to have a better handle on their finances and may have received tax refunds. For example, HCFANY recommends the open enrollment period run February 15 – April 15, or after tax season from April 15 – June 15. In the alternative, HCFANY strongly suggests a longer open enrollment period that would run from September 15 to December 15. November and December are particularly busy months for consumers, with the Thanksgiving holiday and the lead-up to winter holidays. Additionally, inclement weather is possible during this time; this year, inclement weather prompted the NY State of Health to extend by 5 days the enrollment deadline for January 1 coverage.

A longer open enrollment period will give consumers sufficient time to select coverage and to get help from consumer assistors, if needed. In addition, a longer open enrollment period would provide enrollment assisters more time to advertise their services and conduct outreach. Since funding for enrollment assisters is limited, and therefore restricts the amount of consumers enrollment assisters can help, extending the open enrollment period would provide assisters with more opportunities to work with consumers, which would provide more opportunities for consumers to successfully enroll.

Special Enrollment Periods (§ 155.420)

HCFANY applauds CMS for adding Special Enrollment Periods (SEP) that promote continuity of coverage, including: (1) an SEP for people affected by divorce, legal separation or death; (2) an SEP for people whose enrollment or non-enrollment is influenced by an error on the part of a non-Exchange entity who provides enrollment assistance; and (3) an extended SEP for people who gain access to new QHPs as a result of a permanent move.

In addition to these, HCFANY urges CMS to add a Special Enrollment Period to address the issue of changing provider networks. Changes in provider networks, which are increasingly common during the plan year, cause many problems for consumers, particularly those with serious health conditions. Some consumers sign up for Marketplace plans based on information about providers' network status and drug formularies, which proves to be inaccurate from the outset. Others sign up for coverage based on networks that are accurately reported at the time of enrollment, but soon become meaningless as plans shed providers or change formularies. In either case, CMS should offer an SEP when a plan's provider network or formulary coverage changes in a materially adverse way to a consumer. Alternatively and preferably, CMS could allow consumers to access providers at in-network rates should their provider leave the network during the plan year, as described in more detail under network adequacy below.

Small Business Health Options Program (SHOP) (§ 155.705)

HCFANY supports allowing Exchanges to collect payments for continuation coverage, but objects to the proposal that would allow a Federally Facilitated Exchange to limit such collection to premiums for federally mandated continuation coverage (§ 155.705(ii)(A)). This proposal could prevent many consumers from opting into continuation coverage options implemented by their state, including options for companies with fewer than 20 employees. New York's Marketplace accepts payments for state-mandated continuation coverage, providing New York consumers with the widest range of options as they depart an employer. HCFANY urges CMS to require that FFE SHOPs accept payment for all forms of continuation coverage in a given jurisdiction, thereby abiding by broader state protections.

Essential Health Benefits (Part 156)

With regard to the Essential Health Benefits (EHBs), HCFANY's comments first address general recommendations to enhance the EHB benchmark approach, and install clear monitoring and enforcement rules. Subsequently, we address CMS's proposals regarding the provision of health benefits; collection of EHB data; prescription drug standards; and non-discrimination.

Essential Health Benefits Approach, Monitoring and Enforcement

In the proposed rule, CMS maintains its general approach to EHBs, which involves each state selecting and enhancing a benchmark plan to cover 10 specified EHBs (§156.110). HCFANY urges CMS to revisit this approach in the following two ways to ensure that it adequately meets the health needs of children.

First, HCFANY recommends that CMS obligate states to supplement their benchmark selection for 2017 with pediatric services across all categories. EHB benchmarks are based on the small group market and adult health care needs, and EHB pediatric categories often require supplementation. For example, children need services like developmental assessments and lead screenings with greater frequency and intensity than adults, so benefit limits intended for an older population may be insufficient for many children.[1]

Second, CMS should ensure that states' definitions of pediatric services give children medically necessary care beyond oral and vision services, such as physical, speech and occupational therapy, home health care, and durable medical equipment. This can be accomplished by requiring states to use their 2014 CHIP benefits as the benchmark for pediatric services as soon as possible, and at 2017 at the latest. In addition, CMS should establish stronger transparency standards for states in their review and certification of EHBs to ensure that all benefits are included in full in selections.

[1] http://www.aap.org/en-us/professional-resources/practice-support/periodicity/periodicity%20schedule_FINAL.pdf

HCFANY also requests that CMS clarify how it will monitor and enforce EHB regulations and any potential violations of these regulations. This issue is particularly relevant to mental health and substance use disorder services. HCFANY applauds the CMS' guidance that QHPs need to conform to the provisions of the Mental Health Parity and Addiction Equity Act of 2008. However, CMS should further explain how it will monitor and enforce parity for these and other services, to strengthen the regulation and better ensure access to care.

Provision of Essential Health Benefits (§ 156.115)

HCFANY offers comments regarding the two proposed additions to the provision of EHBs: (1) a definition for habilitative services; and (2) clarification regarding the provision of pediatric services.

First, HCFANY supports the new federal definition of habilitative service coverage under the Essential Health Benefits (§156.115(a)(5)(i,ii)). Providing a standard definition will ensure that individual issuers do not determine habilitative benefits, which can lead to inconsistency across plans. Additionally, HCFANY recommends that CMS establish this definition as a required federal floor, allowing states to set more generous coverage requirements.

Second, HCFANY appreciates CMS' clarification regarding the provision of pediatric services to the end of the plan year in which the enrollee comes of age (§156.115(a)(5)(iii)). However, HCFANY strongly recommends that CMS extend the minimum requirement to age 21. This higher age limit aligns with existing standards under Medicaid and the Children's Health Insurance Plan (CHIP). For example, through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, Medicaid provides preventive and comprehensive health services to children under the age of 21.[2] Extending the provision of pediatric services will help ease transitions between coverage programs and allow children with life-long and chronic conditions to continue care beyond age 19 with pediatric providers who have the expertise surrounding their conditions and treatment that other providers often do not.

Collection of Data to Define Essential Health Benefits (§ 156.120)

HCFANY applauds the efforts of CMS to increase transparency through data collection, as data is necessary to support an open dialogue and participation by all stakeholders and will make it possible to conduct analyses regarding state variability and plan benefits. However, the proposed regulations are less specific about how this data will be used. HCFANY further recommends the following regarding the use of collected data:

- CMS should use collected benchmark data to assess EHBs across states and identify areas of variability. This data can enable departments of insurers to better gauge whether or not EHBs are providing promised benefits to consumers.

[2] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html

- CMS should not only collect and analyze this data, but also make it available to consumers and consumer advocates in an accessible and understandable way.

Prescription Drug Benefits (§ 156.122)

HCFANY strongly supports the proposed improvements to EHB prescription drug benefits, including: (1) the new system for determining compliance with EHB drug benefits; (2) requiring an exceptions process and secondary external review to improve access to medications; (3) measures to improve transparency; and (4) providing choice in how consumers access their medications.

First, HCFANY supports the requirement that plans adopt a pharmacy and therapeutics (P&T) committee to ensure their formulary covers a sufficient number and type of drugs. HCFANY further urges CMS to require this new standard in tandem with the current standard that uses either the most recent AHFS or USP system at the most granular level. Since plans already utilize P&T committees, we urge CMS to institute this process for plan year 2016 and not wait until 2017. If CMS uses the USP system in 2016, plans should be required to use USP Version 6.0 and not 5.0. Version 6.0 was finalized in February 2014 and is more current and reflective of today's FDA approved medications. For the AHFS to be used, it will have to be made accessible to the public.

Second, HCFANY supports CMS's proposed requirement that plans have an "exceptions process" by which enrollees can access medications not on the plan's formulary list, as well as appropriate timelines for emergency health situations. HCFANY additionally supports the requirement that plans offer a secondary external review process. These measures will help patients access necessary medications prescribed for them by their provider. Finally, we are extremely pleased that CMS is clarifying that patient cost sharing for excepted drugs counts toward the maximum cost-sharing limit.

Third, HCFANY supports proposals to increase formulary and provider transparency. In order for patients to select the plans that best meet their individual health care needs, they must have access to easy-to-understand, detailed information about plan benefits, formularies, provider networks, and the costs of medications and services. HCFANY recommends that formularies should be made available in PDF format as well as through a prescription search tool. HCFANY urges CMS to consider an interactive web tool, such as a plan finder or benefit calculator, that matches an individual's prescriptions and provider needs with appropriate plans (such as the one utilized by the Medicare Part D program). Requiring plans to submit information in a standard, machine-readable format can assist in developing such tools.

Fourth, HCFANY strongly supports providing patients with the choice of how they receive their prescriptions and prohibiting the practice of a mail-order only option. New Yorkers have long struggled with mandatory mail order pharmacy policies. New York Legislation in affect since 2012 was supposed to guarantee choice of bricks and mortar pharmacies, but has not worked as intended. CMS's proposed regulations would help New Yorkers and others access prescriptions at

the pharmacy of their choice. Further, this option should be implemented in 2016, as we see no reason to delay until 2017.

Prohibition on Nondiscrimination (§ 156.125)

HCFANY commends CMS on its recognition of the ways in which benefit design can discourage enrollment by some individuals, in effect making those plans discriminatory. We urge CMS to include in this section of the proposed rules an additional focus of nondiscrimination relating to services needed by transgender individuals. These services (such as hormones or gender reassignment surgery) are commonly prescribed for treatment of gender dysphoria. Gender dysphoria, a medical diagnosis that is included in the American Psychiatric Association's diagnostic manual, is used to describe the condition of people whose gender assigned at birth is contrary to the one with which they identify. Research by HCFANY's LGBT Task Force earlier this year found that a number of the QHPs being offered in our NY State of Health Marketplace excluded coverage for some services when they are prescribed for treatment of gender dysphoria. These services are routinely covered by these same health plans for a number of other diagnoses. The result of these disparate coverage policies is discrimination against transgender individuals.

The New York State Department of Financial Services recently issued a circular letter advising health insurers that they may not deny medically necessary treatment otherwise covered by a health insurance policy solely on the basis that the treatment is for gender dysphoria (N.Y. DEP'T OF FINANCIAL SVCS., Insurance Circular Letter No. 7 (Dec. 11, 2014)). Several others states and the District of Columbia have taken similar action. HCFANY urges CMS to include in its final rule a prohibition on discriminatory exclusions of coverage prescribed for medically necessary treatment of gender dysphoria.

Cost-sharing (§ 156.130)

HCFANY supports the clarification that the annual limitation on cost-sharing for self-only coverage applies to all individuals whether or not the individual is covered by a self-only plan or a plan that is other than self-only. However, HCFANY urges CMS to make the same clarification for self-only deductibles, to prevent the case of a single individual being forced to meet a much larger deductible in a family plan. Additionally, HCFANY urges CMS to clarify the application of this requirement by providing specific examples.

Network Adequacy (§ 156.230)

HCFANY urges CMS to act independently to create clear, quantitative, minimum standards for network adequacy, rather than waiting for the National Association of Insurance Commissioners' (NAIC) revision of its network adequacy model act. There is a strong possibility that the NAIC will not be done with its process in time for plans to file their 2016 QHPs. Even if NAIC standards are available in time, states may not take immediate legislative action. Robust network adequacy standards, including standards for time, distance and waiting periods, are essential to ensure that consumers have access to needed care in a timely manner. CMS should

establish minimum standards that will allow states to develop stronger or more robust standards as needed.

HCFANY supports the new proposed requirements to make provider directories more accessible and provider information more transparent to consumers. In addition to the information listed for provider directories, we recommend that plans be required to list their language capabilities, which offices are wheelchair accessible, whether they have accessible bathrooms and whether they have accessible examination tables and chairs, weight scales, radiological equipment, and mammography equipment. New York will be requiring plans to update networks within 15 days of a change, and we urge CMS to adopt this standard for all QHPs, rather than 30 days as stated in the preamble.

The preamble to this rule encourages plans to allow new enrollees to continue a course of treatment with a provider at in-network costs for 30 days if that provider is not in their new plan's networks. HCFANY recommends several revisions to this aspect of the proposed rules. First, this transition period should be required, and the period should be extended to 90 days, as is required in New York for people who are joining Managed Long Term Care Plans. Additionally, pregnant women should be allowed to keep their non-network provider for the duration of the three trimesters of pregnancy and the initial postpartum visit, as soon to be required by Maryland statute.[3] Finally, consumers should be allowed to access a provider at in-network rates should the provider leave the network during the middle of a plan year or if the provider directory was out of date and inaccurately listed the provider as in-network. If the consumer signs up for a plan because of a specific provider network, and the provider network changes after the consumer is locked into the plan, the risk should fall on the plan for this change, not on the consumer.

Segregation of Funds for Abortion Services (§ 156.280)

HCFANY strongly supports CMS's clarification of existing federal statutes and regulations regarding accounting and other standards for issuers of QHPs that cover abortion services. Further, HCFANY urges CMS to include these clarifications in the final rule. Section 1303(b)(2)(B) of the ACA, and its implementing regulations, require that QHPs covering non-excepted abortion services collect payment from federally subsidized enrollees related to the non-excepted services. As the preamble clarifies, states have some flexibility to implement these rules. Under the law, QHPs may issue to federally subsidized enrollees one non-itemized bill indicating the total amount for all coverage provided under the plan. Federally subsidized enrollees may pay their bill (for non-excepted abortion services and for all other services) in a single transfer of funds. Indeed, a number of states, including New York, have already issued guidance consistent with these rules. The New York State Department of Financial Services Circular Letter to QHPs offered through New York's marketplace explains that "QHP issuers will be in compliance with the ACA if they do not itemize non-excepted abortion services on the

[3] MD. CODE ANN., INS. § 15-140(c)(2)(ii) (effective January 1, 2015)

premium bill and collect both premiums through a single transfer of funds." N.Y. DEP'T OF FINANCIAL SVCS., Insurance Circular Letter No. 7 (Sept. 18, 2013).

Plan Variations (§ 156.420)

HCFANY strongly supports the requirement that issuers make available to individuals eligible for cost-sharing reductions a Summary of Benefits and Coverage (SBC) that accurately represents the plan variation based on this financial assistance. Consumers cannot otherwise understand how the cost-sharing requirements of their plan will differ from the standard silver plan. Such information is critical both for plan selection as well as understanding plan benefits and cost sharing once enrolled. In the absence of this information, some consumers who would be eligible for cost-sharing reductions may choose bronze level coverage with substantially lower premiums based on a comparison of standard plan materials. Having an accurate SBC would allow for a true comparison and more complete understanding of plan choices.

Quality Improvement Strategy (§ 156.1130)

HCFANY supports the proposed quality standards and the requirement for each QHP issuer to develop a Quality Improvement Strategy (QIS). Additionally, HCFANY supports the aims of the proposed QIS: improving health outcomes; implementation of activities to prevent hospital readmissions; implementation of activities to improve patient safety and reduce medical errors; implementation of wellness and health promotion activities; and implementation of activities to reduce health and health care disparities. These goals align with existing payment and delivery system reforms currently underway in New York State through the Delivery System Reform Incentive Payment program (DSRIP). Considering the similarity of these goals, HCFANY strongly supports the idea of aligning new data collection requirements with those existing requirements in each state. Such an alignment will ease any administrative burdens and allow providers and insurers to focus more attention on achieving meaningful quality improvement. Additionally, HCFANY suggests that a QIS outline separate requirements for collecting data on children. The CHIPRA Core Set of Children's Health Care Quality Measures would be a good foundation for establishing these requirements.

In order for the QIS to make a meaningful impact in reducing health disparities, HCFANY proposes two additions to the regulations. First, the current regulation states that the "QHP issuer's QIS will focus on one or more of the following topics outlined in section 1311(g)(1) of the Affordable Care Act." HCFANY recommends that a QHP be required to report on any area in which they undertake activities aimed at achieving the above referenced goals, not simply one or more. Second, HCFANY suggests that issuers be required to collect data - to the extent possible - that highlights disparities faced by subgroups of enrollees. For example, the QIS should be sure to collect health data on services and outcomes for lesbian, gay, bisexual, transgender (LGBT) enrollees.

Thank you for the opportunity to provide comments on the HHS Notice of Benefit and Payment Parameters for 2016. If you have any questions about our comments, please contact Amanda Peden at apeden@cssny.org or at (212) 614-5541.

Very truly yours,

Amanda Peden, MPH
Health Policy Associate
Community Service Society of New York