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

March 8, 2016

Ms. Donna Frescatore
Executive Director
New York State of Health
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Mr. Troy Oechsner
Deputy Superintendent for Health
NYS Department of Financial Services
One Commerce Plaza
Albany, NY 12257

RE: HCFANY Recommendations for NY State of Health 2017 Plan Invitation

Dear Ms. Frescatore and Mr. Oechsner:

Health Care for All New York (HCFANY) is a statewide coalition of over 170 organizations seeking to secure affordable, quality health care for all New Yorkers. HCFANY applauds the NY State of Health Marketplace (NYSOH) for successfully enrolling over two million New Yorkers in quality, affordable health coverage. We write to thank you and your staff for your dedication to building the nation's leading consumer-friendly Marketplace that offers high standards for participating plans, affordable coverage and robust consumer protections.

We would like to take this opportunity to offer our insights as you prepare to release the 2017 plan invitation. Some of these recommendations build upon our correspondence concerning last year's procurement (*see* HCFANY letter dated March 10, 2015); other recommendations are new, based upon consumer experiences reported to our coalition this past year. Our comments fall into three categories: (I) provider network issues; (II) affordability; and (III) consumer protections.

I. Provider Network Issues

In the 2017 Marketplace plan procurement process, HCFANY urges the State to consider five steps to improve networks for New Yorkers, including: (A) requiring all plans to offer out-of-network coverage options at the Silver and Platinum levels; (B) improving standards for the provision of information about plan networks; (C) adopting policies to protect consumers from changing networks and formularies; (D) permitting enrollees to select a Primary Care Provider

(PCP) during the NYSOH enrollment process; and (E) convening a multi-stakeholder advisory committee to strengthen network adequacy requirements and enforcement.

A. Consider Requiring Out-of-Network Options for All Silver and Platinum Plans.

Currently, there is no requirement that Marketplace plans must offer out-of-network coverage. Only three Marketplace plans offer out-of-network coverage in 2016 in just a few counties, sprinkled around Western New York, the Capital District and the North Country. As a result, out-of-network coverage is essentially unavailable to most New Yorkers. According to a survey conducted by the Law Office of Mark Scherzer, Esq., only New York and two other states do not have out-of-network offerings widely available to individuals, rendering our state an outlier.

Consumers value out-of-network coverage options because out-of-network coverage provides them with the ability to maintain long-standing provider relationships despite changes in networks. Moreover, when out-of-network coverage options are available, New Yorkers routinely choose them. In 2015, 21% of New Yorkers who had out-of-network coverage options available chose those plans, despite the higher premium costs.[1] Additionally, securing out-of-network coverage has become an important priority in the wake of a recent study indicating that 39% of the plan offerings on the NYSOH are "narrow" network plans.[2]

To address these concerns, HCFANY believes that the 2017 plan invitation should require all carriers to offer options for out-of-network coverage at the Silver and Platinum levels. Coverage at the Silver level is necessary because individuals who need subsidies and cost sharing reductions to afford coverage should not have to choose between affordability and access to the most appropriate specialists. Coverage at the Platinum level is necessary because the consumers who are most interested in out-of-network coverage routinely buy platinum plans. The coverage can be priced fairly to reflect the increased costs associated with the out-of-network benefits, and can be structured so as to not increase costs to consumers who do not choose out-of-network benefits.

HCFANY believes that by requiring out-of-network coverage options on the Marketplace, New Yorkers will be ensured access to the care they need, at an extra cost, from accessible and trusted providers.

B. Consider Establishing Standardized Disclosure Rules About Plan Networks.

Marketplace enrollees must make critical and financially significant choices between health plans without essential information, such as how many providers or hospitals are in a plan's network. While HCFANY understands that the Marketplace is building a uniform provider network portal, an undertaking we endorse and applaud, that portal is not yet available

[1] New York State of Health, 2015 Open Enrollment Report (July 2015).
[2] University of Pennsylvania and Robert Wood Johnson Foundation, "State Variation in Narrow networks on the ACA Marketplaces," August 2015, available at: http://www.rwjf.org/en/library/research/2015/08/state-variation-in-narrow-networks-on-the-aca-marketplaces.html.

and does not appear to be coming on-line for some time. The Marketplace currently does not provide easy access to information about individual providers or facilities participating in a plan's network. Consumers seeking this information are directed to provider websites that have no standardized content or formats, and so are unable to make apples-to-apples comparisons or realistically assess the capacity of a plan's network. Often, consumers have to conduct tedious, "multi-click/drop-down menu" steps for individual provider searches to get a comprehensive picture of a plan's network. And each carrier's website follows a unique format, resulting in a cumbersome process for all.

Until there is a provider network portal on the Marketplace, HCFANY urges the State to improve the information metrics available about individual providers and facilities and the overall size of networks. Our four specific recommendations are as follows: (1) standardize provider directories; (2) ensure that the directories are accurate; (3) mandate consumer-friendly search functions; and (4) disclose metrics describing network sizes.

1. Consider Requiring Standardized Provider Directories

While the NYSOH now has a more accessible list of provider directories than existed last year, the linked directories vary widely in content and style causing considerable confusion and frustration for consumers. In addition, the NYSOH website does not provide any links to Medicaid Managed Care or Child Health Plus plan provider directories, making it all the more challenging for these enrollees to conduct provider searches.

The provider directories continue to be challenging for consumers to use. Many of the NYSOH directory links send consumers to pages that incorporate needless intermediary steps, for example, by placing the actual directory links at the bottom of the page (and in very small type).[3] Moreover, not all the directories include information about provider language capabilities or accessibility for people who use wheelchairs despite the requirement in the 2016 plan invitation to do so.

In the absence of a centralized provider directory or a way for consumers to access the standardized information reported to the Provider Network Database System, the State should consider creating content and format standards for the plan provider directories to which the NYSOH website links.[4] Those specifications should apply to Qualified Health Plans, Medicaid, Essential Plan and Child Health Plus plan directories, all of which should be linked to from the NYSOH website. Plans also should be required to make the directories machine-readable, as CMS has for the federal marketplace.[5] This would allow third parties to create better tools than are available on the Marketplace.

[3] For an example, see the MetroPlus page that the NYSOH sends consumers to when seeking a provider directory: http://www.metroplus.org/marketplace?xx=xz&lang=en-US.

[4] This is already done in California, *see* CA SB 137, available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB137.

[5] Centers for Medicare & Medicaid Services, *FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces* (February 20, 2015) at 24, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf.

2. Consider Requiring Accurate Health Plan Directories

While NYSOH develops a well-functioning provider search tool, the NYSOH should consider requiring all health plans to maintain the accuracy and integrity of their provider directories. Consumers and Navigators routinely find that plan directories are either incorrect or inconsistent with information available from physicians' offices.[6]

According to a pilot study conducted by HCFANY of seven health plans' websites (five Qualified Health Plans and two Medicaid Managed Care Plans), 52% of the provider directories surveyed were inaccurate. Accuracy was determined based on whether the on-line directory correctly listed the following: provider name, phone number, address, insurance accepted, language(s) spoken and hospital affiliation.

To address these issues and others, all provider directories should conform to the new State Insurance Law requirement that network changes be updated at least within 15 days.[7] Marketplace plans should be required to proactively communicate with providers to verify data through regular audits and provide a process for the public to report inaccuracies. The State must also conduct its own audits to verify the accuracy of provider directories. Finally, plans should be required to honor the information about in-network providers that consumers receive from their directories. Consumers should be held harmless for plans' inability to provide accurate information.

These recommendations align with federal standards and with best practices reported for other states.[8] For example, CMS is using a contractor to directly monitor provider directories for Medicare Advantage plans in response to widespread accuracy problems.[9] Plans that fail to maintain quality provider directories may face fines or enrollment sanctions. California and Texas require plans to provide a process for the public to report inaccuracies and to honor false information provided through the directories.[10]

3. Consider Mandating Consumer-Friendly Search Functions

While NYSOH develops a high-performing provider search filter, the NYSOH should send consumers directly to accurate searchable provider directories associated with each specific Marketplace offering.

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[6] For example, Oscar's decision to drop New York-Presbyterian Hospitals and their affiliated physicians after March 31, 2016, was not made immediately available to the public during open enrollment; consumers reported first learning of the network change from their providers.

[7] *See* N.Y.S. Ins. L. §3217-a(17).

[8] *See* Families USA, Improving the Accuracy of Health Insurance Plans' Provider Directories, (October 2015), http://familiesusa.org/sites/default/files/product_documents/ACA_Provider%20Directory%20Issue%20Brief_web.pdf.

[9] Centers for Medicare & Medicaid, *Advance Notice of Methodological Changes for Calendar Year (CY) 2016 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2016 Call Letter*, (February 20, 2015), at 135, https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2016.pdf.

[10] Families USA, at 7-8 and 10.

Some of the provider directory links instead send consumers to static documents or require a burdensome amount of information to find out if a doctor is in-network (e.g. Empire requires zip code, state, plan type, and network to retrieve this information). Searches of provider directories should provide a clear indication of whether providers are accepting new patients, including the specific in-network facilities at which providers have openings. Consumers should be able to search according to languages spoken by staff and accessibility for people with disabilities. Finally, consumers should be able to filter provider search results by those providers accepting new patients, in order to obtain the most accurate picture of network capacity.

HCFANY recommends looking to Oscar Health's provider search function as a user-friendly model, as it requires only entering a provider's last and first name, specialty, or zip code.

4. Consider Adopting Metrics that Disclose the Plans' Network Sizes

HCFANY has long argued that the Marketplace should rate or label plans according to network size. We are pleased to see the recent determination that the federal Marketplace will be rating plan networks and encourage New York State to follow suit as part of this year's plan certification process.[11]

As described above, a national survey of Marketplace plans, conducted by researchers from the Robert Wood Johnson Foundation and the University of Pennsylvania found that 39% of the networks offered on the NYSOH are considered narrow, which means that less than 25% of providers within a plan's rating area participate in the plan's network.[12] However, New York's consumers have no way of knowing which of the plans they are considering fall into the 39% considered by national experts to be narrow. It is unreasonable to ask New York's individual and small group consumers—who do not have the benefit of expertise from a human resources department or union benefits administrator—to buy (or select) plans blindly without any comparative disclosures about the size of provider networks. New York State should be a leader in helping our health consumers have the most information possible when they purchase health plans, which, for many, is one of the greatest single expenses after housing.

There are also other dimensions of narrowness that matter to consumers (e.g. ratio of providers to enrollees, geographic concentration of providers, representation of certain specialty providers). Consumers need ready access to this type of information to realistically assess the access offered by different plans.

HCFANY recommends that NYSOH consider rating the plan networks and furthermore require all NYSOH-certified plans to provide the following details to consumers:

[11] Robert Pear, "Health Law Insurance Plans to be Rated by Network Size", *New York Times* (March 6, 2016), http://www.nytimes.com/2016/03/07/us/health-law-insurance-plans-to-be-rated-by-network-size.html.
[12] Dan Polsky and Janet Weiner, State Variation in Narrow Networks on the ACA Marketplaces, Robert Wood Johnson Foundation, (August 2015), at 4, available at: http://ldi.upenn.edu/sites/default/files/rte/state-narrow-networks.pdf.

- Network size, including the overall number of providers, primary care providers, specialists, and hospitals that are in the network, as well as in each county.
- Number of hospitals, pharmacies, laboratories and diagnostic facilities by county and the ratio of in-network hospitals and pharmacies to total hospitals and pharmacies in each county.
- Provider to enrollee ratio for primary care providers and specialists.
- Geographic concentration of primary care providers and specialists; for example, a mapping function for network providers by zip code to show consumers the number of providers near their home or workplace. This is currently available for Oscar members and should be available for everyone shopping on the Marketplace.

Further, HCFANY urges the State to clearly post these details for all plans on the NYSOH website, updated on a monthly basis, along with a simple label that allows consumers to quickly assess whether a plan network is narrow or broad. The Department of Health already publishes much of this information for Medicaid Managed Care Plans, including network size and provider-to-enrollee ratios, in the *All Plan Summary Report for New York State Medicaid Managed Care Organizations*.[13] This report can be used as a model for posting similar information for all plans on the NYSOH. For example, HCFANY recommends the State post a table of total providers by specialty overall and by county for each plan, modeled after Figure 7, Providers by Specialty. The State should also post ratios of providers to enrollees by plan as in Figure 8, Ratio of Enrollees to Providers.[14]

C. Consider Strengthening Consumer Protections when Plans Change Networks and Formularies.

HCFANY asks the State to consider requiring the plans to establish policies to protect consumers from changing networks and to encourage network stability. Consumers complain that provider networks change too often, causing unnecessary disruptions in continuity of care.[15] Some consumers sign up for Marketplace plans based on information about provider networks and drug formularies that are inaccurate from the outset. HCFANY recommends the State consider three remedies to this problem: (1) prohibit mid-year changes to formularies or terminate providers during the year (with exceptions provided below); (2) provide for an extended transition period of one year to maintain access to providers or drugs at in-network costs; and (3) provide a special enrollment period to consumers when plans make mid-year changes to formularies or provider networks.

[13] New York State Department of Health, Office of Quality and Patient Safety. (April 2015). All Plan Summary Report for New York State Medicaid Managed Care Organizations. Available at: http://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/docs/all_plan_summary.pdf

[14] *Id.*

[15] Network changes can happen on a massive scale. For example, in December 2013 United Healthcare announced it would cancel contracts with over 2,000 doctors, affecting over 8,000 consumers. *See* Kaiser Health News. *United Healthcare Dropping Hundreds of Doctors from Medicare Advantage Plans.* December 1, 2013. Available at: http://kaiserhealthnews.org/news/medicare-advantage-unitedhealthcare-narrow-networks-doctors/.

1. Annual Terms for Providers

First, HCFANY urges the State to require plans to have provider contracts run for annual terms, on the calendar year cycle, concurrent with the plan year, with plans only able to terminate a provider earlier in the event of malfeasance or when patient safety issues are presented. Similarly, drugs should retain their formulary status for the entire plan year, with the exception of adding new prescription drugs or removing those proven dangerous and taken off the market by the FDA.

2. One-Year Continuity of Care Guarantee

Second, the State should consider requiring plans to offer an extended transition period of one year for consumers to maintain access to critical providers and prescription medications after a provider leaves the network or a formulary changes. New York State Law currently requires all insurance carriers, both on and off the Marketplace, to offer a 90-day transition period if an enrollee's provider leaves the network while they are undergoing a course of treatment, as long as the provider agrees to accept the original negotiated rate.[16] However, a 90-day period is not sufficient if the provider is critical to an enrollee's care. The State should consider requiring NYSOH plans to extend the transition period to allow consumers to continue receiving care from a critical provider until the end of the plan year, at which point the consumer will have the opportunity to switch to a more appropriate plan as needed.

3. Special Enrollment Period for Significant Network Changes

Third, the State should consider offering a special enrollment period to consumers affected by mid-year provider or formulary changes. The United States Department of Health and Human Services (HHS) permits a State to offer additional special enrollment periods (SEP) as long as they are more protective of consumers and otherwise comply with applicable laws and regulations.[17] New York recently exercised this option by providing an SEP for pregnant women.[18] Furthermore, HHS has indicated that NYSOH currently has the authority to provide a SEP for mid-year formulary and provider network changes under existing federal regulations.[19]

An Exchange may provide an SEP when a consumer "demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide."[20] HHS has stated that Exchanges retain the flexibility to provide special enrollment periods for exceptional circumstances as determined appropriate by the Exchange.[21] NYSOH could determine that mid-year plan changes constitute "exceptional circumstances" and provide affected consumers with an SEP.

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[16] *See* NY PH Law §4403 (6)(e)(1).
[17] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, Feb. 27 2015, 80 FR 10798, available at: http://www.federalregister.gov/a/2015-03751/p-668.
[18] *See* N.Y. Pub. Health L. §2507, signed by Governor Cuomo on December 22, 2015.
[19] *See* 45 C.F.R. § 155.420 generally, as well as 45 C.F.R. §§ 155.420(d)(9), 155.420(d)(4), and 155.420(d)(5)
[20] 45 C.F.R. §§ 155.420(d)(9).
[21] 79 Fed. Reg. 30239, 30298 (May 27, 2014), Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, available at: http://www.federalregister.gov/a/2014-11657/p-695.

Additionally, an Exchange may provide an SEP when a consumer's "enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange."[22] HHS has explicitly stated that Exchanges possess the authority to define the circumstances that trigger this SEP.[23] NYSOH could find an SEP is warranted when its Customer Service Center and Navigators (and potentially CACs) are under the mistaken impression that plan formulary and provider networks are accurate and will continue throughout the plan year, and help enroll people under this mistaken belief. NYSOH could determine those consumers erroneously enrolled in a QHP as a result of misrepresentation, error or inaction on the part of the Exchange, and are entitled to an SEP.

Finally, NYSOH could provide an SEP when a consumer "adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee."[24] HHS specifically contemplates this provision be used by Exchanges to remedy the effect of substantial mid-year network changes.[25] Through the plan certification process, NYSOH could provide an SEP to consumers affected by substantial mid-year formulary and provider network changes.

D. Permit Selection of Primary Care Provider Upon Enrollment.

HCFANY urges the State to improve the enrollment process by permitting consumers to select their primary care provider when they enroll in coverage. Consumers routinely express concern about the length of time it takes for them to select a primary care provider and have their choice recognized by the plan. We understand that this concern is shared by the Coalition of Public Health Plans. We join with that Coalition to urge the State to develop this functionality in the New York State of Health Marketplace enrollment process as soon as possible.

E. Convene a Multi-Stakeholder Group on Network Adequacy.

HCFANY encourages the Department of Health, the Department of Financial Services and Marketplace staff to convene a multi-stakeholder advisory committee to develop network adequacy recommendations to: (1) make required provider counts more robust; (2) create appointment availability standards; (3) ensure network adequacy standards meet the needs of a diverse group of consumers; and (4) monitor and enforce network adequacy in Marketplace plans. HCFANY's recommendations are below, but the details and implementation would best be carried out by a multi-stakeholder working group that includes plans, providers, and consumers in equal proportion.

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[22] 45 C.F.R. § 155.420(d)(4).
[23] 79 Fed. Reg. 30239, 30298 (May 27, 2014), Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, available at: http://www.federalregister.gov/a/2014-11657/p-695.
[24] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, Feb. 27, 2015, 80 FR 10799, available at: http://www.federalregister.gov/a/2015-03751/p-682.
[25] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, Feb. 27, 2015, 80 FR 10799, available at: http://www.federalregister.gov/a/2015-03751/p-682.

1. Provider Counts

First, HCFANY recommends that the multi-stakeholder advisory committee consider network adequacy requirements that include explicit provider-to-enrollee ratios for all Marketplace plans—Qualified Health Plans, the Essential Plan, Child Health Plus and Medicaid Managed Care.[26] The 2016 Plan Invitation does not include ratios for any providers except dentists. The outdated plan guidelines for other providers are at least three primary care physicians and at least two specialists from each required category—this ratio is a ludicrously low standard in places such as New York City where there are well over three primary care providers per plan in all plans, rendering the whole process a sham. Similarly, New York's Medicaid Managed Care model contract requires that plans have no more than 1,500 enrollees per physician—but doesn't control for duplicated counts across health plans.[27] Though the 2016 plan invitation does say that plans may be required to add providers based on enrollment numbers, there are no guidelines for when this is triggered. Without explicit, meaningful standards for provider-to-enrollee ratios, Marketplace plans in larger regions may not have a sufficient number of providers to meet enrollees' needs. Such ratios could be discussed and consensus forged through the advisory committee process.

2. Appointment Availability

Second, the multi-stakeholder advisory committee could develop specific appointment availability standards, which apparently do not exist for Qualified Health Plans, the Essential Plan and Child Health Plus. The lack of appointment availability standards means a plan on the Marketplace could theoretically meet network adequacy standards while having no providers accepting appointments. In contrast, New York's Medicaid Managed Care model contract includes standards related to appointment availability for routine and urgent care and in office waiting times.[28] For example, patients must be able to make an appointment within 24 hours for urgent care, within 72 hours for sick visits and within four to six weeks for non-urgent specialist care. Appointment waiting times are limited to one hour for enrollees.

3. Diverse Consumer Voices

Third, the multi-stakeholder advisory committee could consider standards that meet the particular network adequacy needs of diverse groups of consumers, including but not limited to women, low-income people, people with disabilities, limited English Proficient (LEP) New Yorkers, people with mental illness, LGBT people and people of color. These consumers and

[26] Enrollee-to-provider ratios and appointment waiting times were highlighted as best practices for network adequacy highlighted in a 50-state survey and report by consumer representatives to the National Association of Insurance Commissioners. *See* Health Management Associates (November 2014), *Ensuring Consumers' Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market.* Available at: http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf.

[27] *See* NYS Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract (March 1, 2014. Section 21.12, Available at: http://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.

[28] *See Ibid.* Sections 15.2 and 15.4.

their representatives are routinely excluded from State policymaking conversations that directly impact their access to health care. HCFANY's LGBT Task Force engaged key stakeholders and uncovered severe network adequacy problems for individuals requiring transgender-specific care through a series of listening sessions conducted in the fall of 2015 in collaboration with DFS. Developing a diverse multi-stakeholder advisory committee would enable opportunities for more traditionally excluded populations to contextualize the impact of network adequacy problems.

The efforts made by other states in this regard can be instructive for New York. To provide just two examples, Connecticut and Minnesota have requirements with respect to the inclusion of Essential Community Providers, and California and New Mexico both have requirements concerning language-accessible and culturally competent care.[29] The task force should examine these requirements and build on them, based on the priority health needs of our state.

4. Monitoring and Enforcement

Finally, the multi-stakeholder advisory committee could develop recommendations for auditing, monitoring and enforcement. This would establish a level playing field for plans, but also provide assurance to Marketplace consumers that their plans are well regulated and monitored. Currently, Marketplace plans are not monitored for network adequacy in a transparent manner. The State should conduct an audit of network adequacy similar to the State's Medicaid Managed Care Access and Availability Survey conducted by the External Quality Review Organization (EQRO) and report these results out to the public.[30] The audit could assess factors such as plan compliance with appointment availability and wait time standards. HCFANY further recommends the State explore enforcement mechanisms, such as fines, for plans that do not comply with transparency requirements and/or network adequacy standards.

II. Affordability

The NYSOH must be vigilant about ways to keep costs down for consumers. While some aspects of costs to consumers are in the control of the federal government or addressed by out-of-pocket limits, there are some actions the State could take. HCFANY suggests: (A) covering more pre-deductible services for Silver plans; (B) eliminating non-standard plan loopholes that distort the subsidies available to consumers; and (C) requiring plans to include information about prescription drug assistance programs with their formularies.

A. Consider Covering More Pre-Deductible Services for Silver Level Plans.

[29] Families U.S.A., "Standards for Health Insurance Provider Networks: Examples from the States" (November 2014), at 6, 9, http://familiesusa.org/sites/default/files/product_documents/ACT_Network%20Adequacy%20Brief_final_web.pdf.

[30] *See* New York State Department of Health, Office of Quality and Patient Safety (May 2014) "All Plan Summary Report for New York State Medicaid Managed Care Organizations," at 13. Available at: http://www.health.ny.gov/statistics/health_care/managed_care/plans/reports/docs/all_plan_summary.pdf.

New York should consider addressing the lingering affordability concerns for consumers by requiring the coverage of more benefits on a pre-deductible basis in the Standard Silver Level plan.

HCFANY commends New York for adopting the affordable Essential Plan option (formerly known as the Basic Health Program) which, for most New Yorkers, has replaced the lowest two levels of Cost Sharing Reduction plans. But a recent Kaiser report found that there are still large numbers of people who are eligible to purchase plans through the Marketplace but have not done so—especially for those falling between 100% and 300% of the federal poverty level.[31] Affordability is likely a factor. In New York, the roll out of the Essential Plan addressed affordability for people between 150% and 200% of the federal poverty level. However, there are still a significant number of eligible but unenrolled individuals between 200% and 300% of the federal poverty level.

Even with the cost-sharing reductions for people between 200% and 250% of the federal poverty level, the 2016 Standard Silver Plan has a deductible of $1,500, which is significantly higher than the $1,200 applied to the same group in 2014. It is also substantially higher than the no-deductible Essential Plan experienced by their slightly lower-income counterparts. Over the past two years, HCFANY has urged the State to reduce these deductibles. Consumers often express concern that these deductibles render the Silver product unaffordable and un-usable for medically necessary care. However, in our discussions with the State, we have come to understand that these higher deductible Standard Silver plans are mandated by the federal rules governing the actuarial values for Marketplace plans.

HCFANY urges the State to consider another method to mitigate the impact of high Silver plan deductible by redesigning the Standard Silver plan benefit package to offer more first dollar options. Currently, only preventive care and pharmacy benefits can be accessed prior to the deductible. Other states offer additional first dollar coverage benefits as described in the Appendix in this letter. For example, according to Families USA, the federal Marketplace and the State Marketplaces of California, Connecticut, Washington DC, Massachusetts, Oregon and Vermont all offer primary care (sick visits) and specialty care visits *pre-deductible*, in their Silver Standard plans. (*See* Appendix to this letter.) All of these Marketplaces, except for DC, offer mental health outpatient visits on a pre-deductible basis. (*Id.*).

HCFANY stands ready to work with the State to redesign the Standard Silver plan option so that more services are offered on a pre-deductible basis.

[31] Larry Levitt et al., "Assessing ACA Marketplace Enrollment," Henry J. Kaiser Family Foundation (March 4, 2016) Available at: http://kff.org/private-insurance/issue-brief/assessing-aca-marketplace-enrollment/?utm_medium=nl&utm_source=internal&mkt_tok=3RkMMJWWfF9wsRokuanLcO%2FhmjTEU5z17OouW6S%2FlMI%2F0ER3fOvrPUfGjI4ET8JrMa%2BTFAwTG5toziV8R7LMKM1ty9MQWxTk.

B. Consider Maximizing the Second Lowest Cost Silver Plan Value by Eliminating the Non-Standard Plan Loophole for Age 29 or other De Minimis Benefits that Impact the Value of the Second Lowest Cost Silver Plan.

HCFANY urges the State to include a provision in the Plan Certification process that will ensure that the Second Lowest Cost Silver Plan is significantly different in value that the lowest cost Silver plan. For example, the State should consider requiring the inclusion of the State's "Age 29 law" in all plan benefit designs—both standard and nonstandard—in the Plan Certification process for 2017 offerings. Last year, the plan certification process permitted the offer of a non-standard plan that included the Age 29 law. While we support the inclusion of the Age 29 law as a benefit, the unintended consequence of this offer was that the Second Lowest Silver Plan offering could have only a $1 difference in price from the lowest cost Silver plan. This means that fewer federal subsidy dollars flowed into New York State for the benefit of our consumers.

HCFANY urges the elimination of this loophole so that health plans must offer significantly different plan designs at the lowest premium levels in order to maximize federal financial assistance for New York's consumers. Alternately, like the California Marketplace, the State could reserve the right to disallow low-end offerings to ensure that subsidies are maximized for New York's consumers.

C. Require Plans to Inform Enrollees About the Ryan White AIDS Drug Assistance Program.

HCFANY recommends the State require QHP issuers to provide information to enrollees, and prospective enrollees, about the potential availability of assistance in paying for certain high-cost medications and premiums from the Ryan White AIDS Drug Assistance Program. When the Kaiser Family Foundation looked into discriminatory formulary policies targeting people living with HIV or AIDs, it found that consumers were largely unaware of Ryan White premium assistance, and no participants in their New York focus group received this premium support.[32] Plans should provide information about this and other drug assistance programs in their drug formularies.

III. Consumer Protections

Consumers who buy plans through the NYSOH should be able to expect customer-friendly approaches that match or exceed requirements in other states. They should also be able to expect protection from discrimination based on their health condition or gender. New York State must continuously monitor plans sold on the Marketplace for activities that are not fair to enrollees. To that end HCFANY recommends: (A) extending the grace period for failing to pay for children's coverage to 60 days or more; (B) requiring carriers to pay directly for assignments

[32] *See* J. Kates et. al., "Health Insurance Coverage for People with HIV Under the Affordable Care Act: Experiences in Five States," Issue Brief from the Kaiser Family Foundation (December 2014), accessed at http://kff.org/hivaids/issue-brief/health-insurance-coverage-for-people-with-hiv-under-the-affordable-care-act-experiences-in-five-states/.

of benefits; (C) prohibiting discriminatory drug formularies; (D) enforcing compliance with regulations on gender dysphoria treatment; and (E) enforcing compliance with contraceptive regulations.

A. Consider Extending the Grace Period for Failing to Pay for Children's Coverage from 30 to 60 days.

New York has a long and laudable history of offering children's health coverage. Our Child Health Plus program has the most generous income and immigration rules in the nation. As a result, only 3.2% of our child population remain uninsured.[33] However, eight other states have begun to pass our historically low children's uninsurance rates, including: Massachusetts, Washington DC, Vermont, West Virginia, Hawaii, Maryland, Iowa, and Rhode Island. While a number of factors may be the cause for our ranking (including the diversity of our population), one important factor that New York policymakers can address is our overly restrictive premium payment policy.

According to a January 2016 report from the Kaiser Family Foundation, New York is only one of three states—Utah and Florida are the others—that has a very short 30-day grace period before a child loses coverage for non-payment of a premium. All the other states surveyed provided much longer grace periods, for example:

- 15 states provide a 60-day grace period before a child loses coverage for failure to pay a premium (AZ, CA, DE, GA, IL, IA, KS, LA, MD, MA, MI, NJ, VT, WI, and NV);
- Two states provide a 90-day grace period before a child loses coverage for failure to pay a premium (PA and WA); and
- Four states provide grace periods of up to 12 months (ME) or until renewal (CT, ID, WV) before terminating a child's coverage for non-payment of premium.

New York should join the majority of other states and offer a longer grace period for failure to pay a child's health insurance premium. This change could be effectuated in the 2017 plan procurement process.

B. Consider Requiring Carriers to Pay Providers Directly for Assignments of Benefits.

Currently, some carriers pay the enrollee directly for otherwise authorized out-of-network services rather than issuing payment directly to the provider. This practice often results in confusion on the part of the enrollee and balance billing by the provider.

Requiring payment to be made directly from the carrier to the provider would improve the enrollee and provider experience in three ways. First, this requirement would provide fairness to providers, who may otherwise not receive the payment made directly to the enrollee. When

[33] *See* Georgetown University Health Policy Institute, "Children's Health Insurance Rates in 2014: ACA Results in Significant Improvements (October 2015), available at: http://ccf.georgetown.edu/wp-content/uploads/2015/10/ACS-report-2015.pdf.

patients receive reimbursement from their insurer, they often think that they no longer have a debt to the provider. Regardless of the reasons why the patients fail to pay their providers after they receive reimbursement checks, the result is that at least some providers accumulate significant amounts of charges that must be written off as losses. Second, this requirement would eliminate many associated problems with payment and billing. A provider's office is unlikely to be informed that a patient received compensation directly from a carrier, which could cause weeks of delay in the billing process. This confusion may be compounded when the patient has coverage by more than one insurer. Third, this requirement would reduce the amount of litigation between carriers and providers. Many times when there are issues regarding insurers and out-of-network providers, the end result is litigation. This creates significant transactional costs, which may negatively affect the cost of health care in general.

Many states, including Alabama, Alaska, Florida, Maryland, Nevada, New Jersey, North Carolina, Oregon, Texas, and Wyoming already require carriers to issue payment directly to providers rather than to enrollees when there is an assignment of benefits to an out-of-network provider.[34] A bill that would require insurance companies to permit consumers to assign their payment of emergency services to their providers is currently pending in the New York State Senate (*see* S6491). However, we believe that this same goal can be effectuated through the plan certification process. HCFANY therefore urges New York to remain a strong consumer protection state and join fellow states that have already passed direct-pay requirements for assignments of benefits to out-of-network providers.

C. Consider Prohibiting Discriminatory Drug Formularies.

HCFANY urges the State to prohibit discriminatory formulary design in the Non-Discrimination section of the Plan Invitation. Consumers with certain chronic conditions, including HIV, Hepatitis C, and multiple sclerosis, have reported that some plans charge higher cost sharing for drugs associated with their chronic condition, or simply don't include them in formularies. Consequently, some consumers have reported difficulties in maintaining their drug regimens.[35] To address this concern, we urge the State to adopt formulary non-discrimination language in the 2017 Plan Invitation that is modeled after language in the U.S. Department of Health and Human Services' 2016 Proposed Notice of Benefit and Payment Parameters.[36] The Preamble to the proposed rule states "if an issuer places most or all drugs that treat a specific condition on the highest cost tiers, we believe that such plan designs effectively discriminate against, or discourage enrollment by, individuals who have those chronic conditions." This approach was adopted in the final rule.[37]

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[34] *See* ALA.CODE § 27-1-19 (1975); *see also* ALASKA STAT.§ 21.54.020 (1997); *see also* FLA. STAT. ANN.§ 627.638 (2009); *see also* MD CODE ANN., INS§ 14-205.3 (2011);*see also* NEV. REV. STAT. § 689A.135 (1983); N.J. STAT. ANN. § 26:2S-6.1 (2011); *see also* N.C. GEN. STAT. ANN. § 58-3-225 (2009); *see also* OR. SEV. STAT. § 743B.460 (2015); *see also* TEX. INS. CODE ANN. § 1204.054 (2005); *see also* WYO. STAT. ANN. § 26-15-136 (1993).

[35] *See D.B.* Jacobs and B.D. Sommers, (January 29, 2015), *Using Drugs to Discriminate – Adverse Selection in the Insurance Marketplace*, N Engl J Med; 372: 399-402.

[36] 79 Fed. Reg. 70723 (Nov. 26, 2014)

[37] 79 Fed. Reg. 80 FR 10749 (Feb. 27, 2015)

D. Consider Enforcing Compliance with Gender Dysphoria Treatment Requirements

HCFANY urges the State to require that in order to be certified for 2017 coverage offerings, plans affirmatively demonstrate that they are in compliance with the December 2014 Department of Financial Services Circular Letter 7, which requires private insurers to cover all medically necessary care in the treatment of gender dysphoria.[38] Last fall, HCFANY's LGBT Task Force conducted a series of three listening sessions around the state, and found numerous serious issues with coverage for care needed by transgender individuals. Many insurers still had categorical exclusions of transgender care, alternative interpretations of the DFS guidance and continued discrimination within their drug formularies. HCFANY recommends that the State require private health insurers to adopt model language for transgender medical coverage provided by Department of Financial Services and require that private insurers provide proof of compliance with the December 2014 Circular Letter 7.

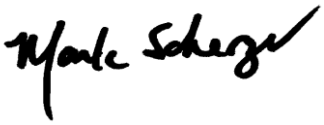
E. Consider Enforcing Compliance with Contraceptive Requirements

HCFANY urges the State to ensure that plans comply with the Affordable Care Act contraceptive coverage requirements. A HCFANY Steering Committee member, Raising Women's Voices-NY, reviewed plan formularies and conducted secret shopper calls to assess insurer compliance with HHS guidance, which requires insurers to cover at least one form of each of the 18 FDA-approved contraceptive methods.[39] Despite the fact that the 2016 model contract language tracked the Affordable Care Act requirements, Raising Women's Voices-NY found that many insurers still are not in compliance. The research identified a number of serious problems with the way contraceptive coverage is presented in the on-line formularies of Qualified Health Plans offered through NYSOH and how birth control coverage is described by customer service representatives. These problems included apparent failure to cover some methods of contraception, descriptions of cost-sharing requirements that violate the FDA guidance, confusing and conflicting information about cost-sharing "tiers" and generally poor customer service by plan representatives who were ill informed and unable to answer our callers' questions. HCFANY urges the State to explicitly require insurers to meet the ACA's contraceptive coverage requirements and enforce compliance with HHS guidance.

[38] New York State Dept. of Financial Services, Insurance circular letter No. 7(December 11, 2014), http://www.dfs.ny.gov/insurance/circltr/2014/cl2014_07.pdf.
[39] FAQS About Affordable Care Act Implementation (Part XXVI) (May 11, 2015), at 4, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/aca_implementation_faqs26.pdf.

We appreciate your consideration of our comments and recommendations as you prepare to release the 2017 Plan Invitation. If you have any questions, please contact Amanda Dunker at adunker@cssny.org or at (212) 614-5312.

Very truly yours,



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cc: PJ Weiner, Director of Plan Management, NYSOH

Standardized Plans: Pre-deductible Coverage

Services Covered Pre-deductible in Silver Standardized Plans:

	FEM	CA	CT	DC	MA	NY	OR	VT
Primary Care	**X**	X	X	X	X		X	X
Specialist	**X**	X	X	X	X		X	X
Mental Health Outpatient	**X**	X	X	X	X		X	X
Lab		X	X		?			
X-Rays		X	X	X	?			
Imaging (CT, MRI)		X	X	X				
Outpatient Surgery		X						
Emergency Room			X					
Ambulance			X		?			X
Urgent Care	**X**	X	X	X	?			X
Generic Drugs	**X**	X	X	X	X	X	X	X
Brand Drugs	**X**		X		X	X	X	
Specialty Drugs	**X**						X	
Rehabilitative (Speech, PT, OT)		X	X	X	?		X	X
Home Health	Not Std	X	X	X	?			
Habilitative	Not Std		X				X	X
DME	Not Std	X	X					?

Comparison of standardized silver plans proposed for healthcare.gov in 2017 with those in State Based Marketplaces in 2016 (compiled by Families USA from public documents - see notes)

	Federal proposal (2017)	California (2016)		Connecticut (2016)		District of Columbia (2016)		Massachusetts (2016)		New York (2016)		Oregon (2016)		Vermont (2016)	
		Copay													
Deductibles and Out of Pocket Limits															
Individual deductible	$3,500	$2,250		$2900 (in-network)		$2,000		$2,000		$2,000		$2,500		$2,000	
Is there a separate drug deductible?	no, drugs are not subject to a deductible	$250		$150		$250		no, drugs are not subject to a deductible		no, drugs are not subject to a deductible		no, drugs are not subject to a deductible		$150	
Out of pocket limit	$7,150	$6,250		$6,850		6250		6,850		5500		6,350		5600	
separate drug out-of-pocket limit?	no, limit above applies to all services	no, limit above applies to all services		no, limit above applies to all services		no,limit above applies to all services		no, limit above applies to all services		no, limit above applies to all services		no, limit above applies to all services		1,250	
Cost-Sharing for Medical Services (for services that are *not* exempt from the deductible, you'd pay the full cost of service until you meet the deductible and then this amount; for exempt services, you will pay only this amount from the outset)															
	Exempt from deductible	**Cost-share**	**Exempt from Deductible**	**Cost-share**	**Exempt from deductible**	**Cost-share (in network)**	**Exempt from deductible**	**Cost-share**	**Exempt from deductible**	**Cost-share**	**Exempt from deductible**	**Cost-share**	**Exempt from Deductible**	**Cost-share**	**Exempt from Deductible**	**Cost-share**
Primary care visit	X	$30	X	$45	X	$30	X	$25	X	$30		$30	X	35	X (office visit/urgent care)	$25
Specialist visit	X	$65	X	$70	X	$50	X	50	X	$50		$50	X	70	X (office visit/urgent care)	$50
Mental Health/Substance Use Outpatient	X	$30	X	$45	X	$30			X	$30		$30	X	Depends on type/place of service	X	$25
Laboratory Services		20%	X	$35	X	$40	X	$45	Not Specified	Not Specified		$50		30%		$25
Diagnostic Tests (X-Rays)		20%	X	$65	X	$50	X	$65	Not Specified	Not Specified		$50		30%		40%

Advanced Imaging (CT, MRI)		20%	X	$250	X	$75/service (Annual Max: 375 for MRI/CT; 400 for PET)	X	$250		$500		$50	30%		40%
Outpatient Surgery Facility Fee*		20%	X	20%		$500				$750		100	30%		40%
Emergency room services		$400		$250/facility plus $50/physician	X	150		$250		500		$150 (0 copay for ER physician)	30%		$250
Emergency transport				$250	X	0		$250	Not Specified	Not Specified		$150	30%	X	$100
Urgent Care	X	$75	X	$90	X	75	X	$90	Not Specified	Not Specified		$70	$90	X	$60
Inpatient Hospital Services*		20%		20%		$500/day (MAX 2000/admission)		20%		1000		1500/admission	30%		40%
Prescription Drug Cost-sharing															
Generic	X	$10	X	$15	X	$5	X	$15	X	$20 (Tier 1)	X	$10 (Tier 1)	X $15	X	$15
Preferred Brand	X	$50		$50	X	$35		$50	X	$50 (Tier 2)	X	$35 (Tier 2)	X $50		$60
Non-Preferred Brand	X	$100		$70	X	$55		$70	X	$75 (Tier 3)	X	$70 (Tier 3)	X 50%		50%
Specialty	X	40%		20% up to $250/script		20% up to $150/script		20%					X 50%		
Rehabilitative services (speech, PT, OT)		20%	X	$45	X	$30 (up to 40 visits	X	$45	Not Specified	Not Specified		$30	X 30% inpatient, $35 outpatient	X	$50 (office visit)

Skilled Nursing		20%		20%		500/day (MAX 2000/admission)		20%		See note		1500/admission	30%		40%
Other Common Essential Benefits That Aren't Standardized in Federal Proposal															
Home health	Not Specified	Not Specified	X	$45	X	NO CHARGE (100 visits)	X	$45	Not Specified	Not Specified		$30	30%		Not Specified
Habilitative	Not Specified	Not Specified		Not specified	X	$30 (up to 40 visits)		?		Not Specified		$30	30% inpatient, $35 outpatient X	X	$50 (office visit)
DME	Not Specified	Not Specified	X	20%	X	40%		20%		See note		30%	30%	Not Specified	Not Specified

* A few states separately list physician fees for inpatient stays and for outpatient surgery.

Additional services standardized in some states

California: prenatal care, other outpatient mental health and substance use disorder items, hospice, children's vision and dental

Connecticut: chiropractic services, diabetic equipmment and supplies, ultrasound mammography and pediatric dental and vision.

District of Columbia: hospice

Massachusetts: Plan comparison tool shows that standard plans are covering skilled nursing with a $1000 copay and DME with 30% coinsurance, but we did not find a document showing the standard.

New York: hospice, hearing aids, eyeware, chemotherapy, radiation therapy, dialysis, and details a number of other specific services.

Oregon: nurse/physician assistant office visit, hospice, cosmetic surgery, prenatal and postnatal care, delivery and maternity care, organ transplants, allergy biofeedback, cardiac rehab, hearing aids, foot care, pediatric vision, sleep studies, vasectomy.

Vermont: In addition to this standard silver plan, Vermont standardized a High Deductible/CDHP plan design.

Note and Sources: We compiled the above chart from descriptions of standard benefits on state marketplace websites, below. Some states may specify additional details in other documents.

California: http://hbex.coveredca.com/regulations/index%20-%202016%20Standard%20Benefit%20Design.shtml

Connecticut: http://www.ct.gov/hix/lib/hix/Standard_Silver_Plan_--_70.pdf

District of Columbia: http://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/FINAL%202016%20DCHBX%20Carrier%20Reference%20Manual%20v1April%202015.pdf

Massachusetts: https://betterhealthconnector.com/wp-content/uploads/Board-Memo-2016-Final-SoA-090415.pdf

New York: http://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20B%20-%20QHP%20-%202016%20Standard%20Plans.pdf

Oregon: http://www.oregon.gov/dcbs/insurance/insurers/rates-forms/documents/training/standard-plan-cost-share-matrix.pdf

Vermont: http://info.healthconnect.vermont.gov/sites/hcexchange/files/VTAHS6317_Silver%20Brochure_20151028.pdf