January 15, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

RE: Draft 2017 Letter to Issuers in the Federally Facilitated Marketplaces (Submitted via email to FFEcomments@cms.hhs.gov)

Dear Acting Administrator Slavitt:

On behalf of the American Heart Association (AHA), including its American Stroke Association (ASA) division, and more than 30 million volunteers and supporters, we appreciate this opportunity to submit comments on Centers for Medicare and Medicaid Services' "Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces."

The AHA/ASA has long advocated for all Americans to have access to affordable, quality health insurance coverage. Access to affordable, quality health care is critical to helping the Association achieve its ambitious goal to prevent as many heart attacks and strokes as possible, as well as to reduce the risk factors for these conditions. We will be releasing data soon about how the Affordable Care Act (ACA) has helped people with cardiovascular disease (CVD) or its risk factors gain insurance coverage. While the coverage gains are important and exciting, we remain committed to ensuring that the coverage meets the needs of our patients.

We commented on a number of these issues in our letter on the Notice of Benefit and Payment Parameters for 2017 (Payment Notice) proposed rule, but we appreciate this additional opportunity to comment on this guidance to issuers. As requested, we have generally limited our comments to provisions specific to the Letter to Issuers (Letter) and hope that HHS will adopt our recommendations as it finalizes both the Letter and the Payment Notice rule.

Chapter 1, Section 4 – Standardized Options

We support CMS's proposal to develop plans with standardized cost-sharing and other features, but urge CMS to require issuers to offer a standardized plan for every metal level for which they're offering a non-standardized plan (or at the least at the silver level), as we recommended in previous comments. In this way, we can be sure that these helpful options for consumers are actually available.

Chapter 2, Section 3 – Network Adequacy Standards

i. Network Adequacy Standard

We appreciate the greater detail that CMS provides in the Letter about its approach to determining network adequacy in 2017. In general, we applaud CMS for recognizing the need to strengthen network adequacy standards and for proposing a number of new protections that would apply for the 2017 plan year. While millions of Americans have gained health insurance over the last two years, that coverage is unfortunately hollow if they cannot access the covered benefits promised to them. Even though the National Association of Insurance Commissioners (NAIC) has now completed its work on its updated Health Benefit Plan Network Access and Adequacy Model Act (Model Act), it is not yet clear how many states will adopt it in whole or in part. Therefore, we strongly encourage CMS to move forward with strong network adequacy standards that can serve as a floor of protection for consumers enrolled in qualified health plans (QHPs) beginning in 2017.

ii. State Review of Quantitative Network Adequacy Standard

CMS reiterates its proposal to rely on FFM states to review QHPs for network adequacy, provided those states use an "acceptable quantifiable network adequacy metric commonly used in the health insurance industry". While we commend CMS for recognizing the need for a quantitative, rather than subjective, approach to determining what constitutes "reasonable access," we are concerned that relying on a single metric will not be sufficient for measuring network adequacy. Therefore, we recommend that CMS require states to use a broad *set* of metrics (that is, at least two) that take into account geographic variations, regionalization of specialty care services, and utilization and practice patterns. The NAIC's Model Act includes a list of quantitative criteria that states could use, such as provider-covered person ratios, geographic accessibility (time and distance) standards, and appointment wait time measures.

In addition, we want to reinforce our strong support for requiring the use of a minimum set of quantitative measures in all states, including state-based marketplaces (SBMs).

iii. Federal Default Standard

It is very helpful to have additional information about CMS's thinking with respect to the federal default standard that CMS would use for determining reasonable access in those FFM states not choosing to review for network adequacy using a quantifiable metric.

While we generally support using time and distance standards, we reiterate our concern that these standards alone are not sufficient. While it is a step in the right direction to require that 90 percent of enrollees have at least 1 provider within xx miles or xx minutes, there still needs to be minimum provider criteria to ensure that a sufficient number of providers with the training and expertise are available to actually serve the specific needs of the covered population. Without also specifying and applying minimum provider-to-enrollee standards, consumers, particularly those in densely populated areas, could find themselves within a few miles of a provider but unable to actually get an appointment due to an insufficient quantity of providers. Therefore, we strongly urge CMS to, at a minimum, enumerate and apply minimum provider-to-enrollee standards for QHPs, as is the case for Medicare Advantage (MA) plans.

With respect to tiered provider networks, we urge CMS to clarify that only providers in the lowest cost-sharing tier will be counted towards meeting the proposed time and distance standards. Using providers who are assigned to a higher cost-sharing tier can result in significantly more out-of-pocket costs, sometimes akin to using out-of-network providers.

CMS solicits comments on both the types of specialties selected and the proposed time and distance standards. We note that generally the provider types being proposed are a subset of the specialty areas reviewed under MA and the time and distance standards are largely the same as those used in Medicare Part C. While using the same standards seems appropriate for many of the specialty areas, such as cardiology and medical oncology, there are some areas where differences in the covered population warrant different standards. More specifically, we make the following recommendations for revising the maximum time and distance standards listed in Table 2.1 in the final Letter:

- Pediatrics: We applaud CMS for acknowledging the need to supplement the MA standards by adding a pediatric standard, as we recommended previously. We note, however, that time and distance to primary care and specialty care providers can be very different, given the regionalization of pediatric specialty care. Therefore, we urge CMS to adopt separate primary and specialty care pediatric standards. The primary care pediatric standards should be more closely aligned with the primary care standards for adults or at least as strong as the standards for common adult medical specialists such as cardiologists or medical oncologists. In addition, a separate set of network adequacy standards that go beyond time and distance would be helpful for pediatric specialties and subspecialties, such as pediatric cardiology.
- Hospitals: With respect to the hospital standards, CMS should make it clear that only acute inpatient hospitals with emergency departments are counted under this standard. If CMS would like to measure inclusion of other types of hospitals, then separate categories should be established for them, as was done for inpatient psychiatric facilities.
- Outpatient Dialysis: We are concerned that the proposed time and distance standards for outpatient dialysis are weaker than MA's standards. Kidney disease is both a major cause of and consequence of CVD so access to dialysis is important to a subset of the patients we represent. These patients are often older, sick and suffer from multiple chronic conditions. In-center hemodialysis patients travel for treatment at least three times a week; 75 minutes of travel time proposed for a rural setting is equal to 6.5 hours of travel a week, 26 hours a month, and 312 hours a year. There has been concern that some QHP issuers have been inappropriately steering end stage renal disease (ESRD) patients under age 65 into Medicare, even when enrolling in a QHP may be in the better interest of the patient. By requiring use of inconveniently located facilities, issuers could discourage enrollment of expensive ESRD patients into QHPs. We therefore urge CMS to adopt the MA standards for outpatient dialysis.
- We note that the MA standards include many more types of specialty physicians and facilities. While we are not suggesting that all of the areas used for MA be incorporated into the QHP standards, particularly for 2017, we do believe that the addition of time and distance standards for the following specialty areas is needed:

- Emergency medicine: We strongly urge CMS to add emergency medicine to the list of specialty providers for which there should be time and distance standards and to align those standards with the hospital standards. This would be a way to help CMS identify where there aren't adequate numbers of emergency department (ED) physicians in the health plan's network. As we have expressed concern about previously, many consumers who need emergency care are surprised to receive large balance bills because the ED physician who cared for them was not participating in their health plan's network, even if they were treated at a participating hospital. Analysis of data from Texas PPO plans by the Center for Public Policy Priorities found that for two of the largest insurers in the state, 48 percent and 56 percent of their in-network hospitals, respectively, had not a single in-network ED physician.[1] This situation leaves consumers vulnerable to balance billing and we find this unacceptable. Establishing time and distance standards for ED physicians would help to ensure that these physicians are being included in health plan networks. While we recognize that MA doesn't have time and distance standards for ED physicians, Medicare also prohibits balance billing by participating providers and imposes strict limits on balance billing by non-participating providers; these protections make such standards less critical for the Medicare population.
- Retail pharmacies: Access to retail pharmacies is critically important to patients, particularly when they have an acute condition and cannot wait for a medication to be mailed to them. We strongly encourage CMS to adopt retail pharmacy access standards similar to those that exist for Medicare Part D.
- Neurology: Given that neurologists are the physicians that generally care for patients with a wide range of neurological conditions that are likely to be experienced by the QHP population, including concussions, migraines/headaches, epilepsy, multiple sclerosis, and stroke, we support adding neurology to the list of specialty areas for which time and distance standards are established for 2017.
- Outpatient therapy: We recommend adding at least one (and preferably all) of the major therapy disciplines to the list, as is the case for MA, as a way of ensuring that adults and children have access to rehabilitative and habilitative care.

Finally, CMS proposes to use a justification process for allowing issuers that do not meet the time and distance requirements to explain why they are unable to do so. Based on its analysis of 2016 QHP issuer network data, CMS estimates that 10 percent of issuers could use this justification process. Unfortunately, such a process does nothing to ensure that consumers enrolled in those plans will have access to an adequate number of providers to provide covered services in a timely manner. Therefore, as part of the justification process, CMS should require issuers to document how they will ensure that enrollees will have access to needed providers without unreasonable delay and at in-network cost-sharing rates. Section 5C of the NAIC's Model Act requires all health carriers to have such a process in place to assure that a covered person can obtain covered services from an out-of-network provider at in-network levels of cost-sharing when an in-network provider is not available without unreasonable travel or delay.

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[1] Pogue S, "Surprise Medical Bills Take Advantage of Texans: Little known practice creates a "second emergency" for ER patients," Center for Public Policy Priorities, September 15, 2014. Available at: http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf.

iv. Provider Transitions

As we did in our comments on the Payment Notice proposed rules, we commend HHS for recognizing the need for consumer notification and a transition period when one of their providers is being discontinued from their plan's network. We generally support these proposals, but encourage CMS to carefully consider and implement our previous recommendations for improving upon them as you finalize both the Payment Notice rule and the Letter.

v. Network Transparency

We are very enthusiastic about CMS's proposal to provide a rating of each QHP's relative network breadth on HealthCare.gov, and we strongly urge CMS to move forward with implementing this system for the 2017 plan year. Currently, consumers have no way of knowing what the relative breadth of their plan's network is. Particularly with the growth of plans with narrow networks and no out-of-network coverage, it is critically important that consumers understand the network that comes with the plan they are choosing and the trade-offs that come with that choice. Plans with narrow networks may be an appropriate choice for some consumers, but they should know that is what they are buying and that the choice may result in higher out-of-pocket costs later if they need to go out-of-network.

We appreciate the additional detail included in the Letter about the methodology CMS is considering using, and we offer the following recommendations for improving it:

- With respect to the provider areas that CMS is proposing to review and for which it will provide a network breadth classification, we commend CMS for planning to provide separate ratings for breadth of network by categories of providers as well as a composite rating of overall network breadth, as we recommended in our comments on the Payment Notice. However, in addition to focusing on hospitals, adult primary care, and pediatric primary care, we encourage CMS to also consider adding separate classifications for the most commonly used specialty physicians for 2017. For example, we recommend that CMS add the following categories of provider classifications:

    - ED physicians who practice at an in-network hospital;
    - Adult physician specialists (non-ED physicians, such as anesthesiologists and pathologists) who practice at an in-network hospital;
    - Adult specialists who practice in office-based settings, such as cardiologists and psychiatrists; and
    - Pediatric specialists.

    Including physician specialists is important for a number of reasons: First, a composite rating that includes only primary care providers could mask networks that include a large number of primary care professionals but few specialty physicians, leaving consumers with an inaccurate picture of their anticipated access to specialty care. Second, in addition to having an understanding of the network breadth for providers they are likely to use (primary care providers and hospitals), it is perhaps even more important that consumers understand the breadth of their plan's network

when it comes to providers that they do not anticipate needing but may very well require if they experience a medical emergency or are diagnosed with a serious illness. The categories we propose adding would give consumers a better understanding of their ability to access the care they need in those unexpected circumstances. Third, consumers with chronic illnesses will find it very helpful to have an understanding of their plan's network breadth with respect to specialty care. In future years, CMS should consider expanding the categories of specialists so that consumers with particular conditions could obtain rating information on different aspects of their care.

- We also recommend that CMS use a broader set of providers as the denominator when calculating the Provider Participation Rate, instead of using only the total number of providers contained in QHP networks. For instance, CMS could instead use the total number of licensed physicians or hospitals for each category type as the denominator or the number of Medicare providers for that category (although a different data source would likely be needed for the pediatric categories).

  Such an approach would give consumers a more accurate picture of a network's ability to meet their health care needs. This measure of network breadth will not be as impacted by the types of QHPs available in the local market and their approach to provider contracting. Under the proposed methodology, a market dominated by non-staff model HMOs (which tend to have narrow networks) would produce a different mean than a market dominated by PPOs with broad networks. A market dominated by staff model HMOs, in turn, would produce yet a different result, as providers in those HMOs don't participate in multiple networks. In addition, under the proposed methodology, all of the issuers in a market could be incentivized to offer narrower networks and, because of the smaller number of total contracted providers, those networks could still be classified as "standard" in that area, even if they are much narrower than other plan networks available in the area, such as those of large employer plans. While the proposed methodology will signal to the consumer that the measures tell them something about the breadth of the network relative to other QHPs available, it will tell them nothing about the absolute ability of the network to meet their expected and unexpected health needs.

- CMS also proposes to develop a composite classification that reflects the overall network, but does not indicate how CMS plans to weight the component measures to develop the composite. We support the development of a composite measure and recommend that it be weighted by overall spending by provider category.

- Finally, we are concerned that the nomenclature being proposed, particularly the "basic" and "standard" labels, are not clear and could be confusing to consumers. "Basic" and "standard" are too similar and neither term appears to be measuring the same thing as "broad." In addition, "standard" may connote that the network conforms to a specific benchmark. We instead suggest the use of "narrow," "average," and "broad" as terms being more intuitive to consumers. However, as for all consumer-facing tools, we once again strongly urge CMS to conduct consumer testing to inform which terminology to use and how best to display this information for the public.

vi. Out-of-Network Cost Sharing

We appreciate that CMS acknowledges the problems that out-of-network cost-sharing poses for consumers when they receive covered services by an out-of-network provider at an in-network facility, often without their knowledge or control. Unfortunately, however, we remain very concerned that the remedy being proposed by CMS in the Payment Notice and Letter does very little to address the financial harm that consumers experience in these situations and is significantly weaker than the provisions included in the NAIC's Model Act. We strongly urge CMS to adopt the recommendations we made in our comments with respect to the Payment Notice when finalizing the rule and this Letter.

Chapter 2, Section 4 – Essential Community Providers

Congress designed the Essential Community Provider (ECP) provision in the ACA to ensure that newly-insured Americans, particularly those who are low-income and may have never had coverage, have access to the trusted providers in their communities. Specifically, Congress identified two categories of ECPs: 340B providers and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, which was principally designed to capture safety net providers that do not receive 340B-qualifying funds. Recognizing that expansions in health insurance coverage must be matched with strong network access protections, section 1311(c)(1)(C) of the ACA was designed to ensure that essential community providers are included in QHP networks—thereby assuring continuity of care and timely access to critical health services.

We are concerned that many QHP networks during the 2014 and 2015 coverage years have left consumers without adequate access to essential health care providers. We commend CMS for its continued focus on the ECP provision, but we are disappointed that the ECP standard has not been improved upon from the 2016 Letter to Issuers.

In particular, CMS has implemented a new ECP petition process for qualified ECPs to submit information in order to stay included on the 2017 ECP list. It is very likely that, since this is a new and rather complex process, many safety-net providers may not successfully submit ECP petitions for all of their locations by the January 15, 2016 deadline. Failure to submit an ECP petition by this deadline removes the provider from the 2017 ECP list, which is a critical list that issuers rely on to identify and initiate discussions with ECPs for inclusion in QHP networks. The conditional write-in process serves as a much-needed grace period while CMS and safety-net providers implement the ECP petition process. The conditional write-in process gives issuers the opportunity to continue working with and contracting with qualified ECPs that may not be on the 2017 ECP list and count these qualified ECPs towards satisfaction of the ECP standard.

Chapter 2, Section 10 – Discriminatory Benefit Design

We applaud CMS for once again including language in the Letter that reminds issuers they must not design plan benefits in a discriminatory manner, by for example discouraging enrollment of individuals with chronic health needs. CMS includes a couple of examples of potentially discriminatory plan design, but we urge CMS to include additional examples that have been identified by the Association in the final Letter, such as:

- Imposing arbitrary and unreasonable quantity limits on outpatient therapy that disproportionately impact patients, such as stroke survivors, who need multiple types of rehabilitative services to recover. In the Association's analysis of more than 300 silver QHPs sold in all 50 states and the District of Columbia in 2015, 16 percent of plans had combined limits of 30 or fewer visits annually for physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services and another 16 percent of plans had individual (per therapy type) limits of 20 or fewer visits. For example, plans in Idaho limit coverage for PT, OT, and SLP services to 20 total visits annually. Similarly, plans in Georgia and Mississippi are imposing a 20 visit annual limit for PT and OT combined and a 20 visit limit for SLP. For a disabled stroke patient who is likely to need all three types of outpatient therapy, this limit translates into only about 2 weeks of outpatient rehabilitation. It is unlikely that most stroke patients can learn how to walk or talk again with such limited coverage.

- Likewise, some plans are also imposing limits on cardiac rehabilitation (CR) that are not sufficient based on the medical evidence. Under the ACC/AHA guidelines, a full course of cardiac rehabilitation is generally 36 sessions over 12 weeks. Research has shown that participating in CR can reduce cardiac mortality by as much as 31 percent and it has also proven beneficial in preventing a second heart attack. Unfortunately, however, contrary to evidence-based medical guidelines, we have seen plans that are imposing inadequate and arbitrary visit limits. In our review and analysis of more than 300 silver QHPs being sold for 2015, we found that 21 percent of the plans that specifically mentioned CR coverage imposed quantity limits of 35 or fewer sessions – meaning coverage does not meet the medical guidelines for CR. For example 2 of the 3 silver plans sampled in Nebraska cover only 18 sessions of CR per cardiac event – half of the amount recommended by the ACC/AHA guidelines. One of the 15 plans sampled in Wisconsin limited CR coverage to only 20 visits. Two of the 15 plans sampled in Texas had a combined quantity limit of 35 visits for CR along with all other types of therapy services.

- Some plans are imposing very high co-pays or co-insurance on specific services more likely to be used by patients with disabling medical conditions, effectively discouraging them from enrolling in those plans or accessing those services. For instance, a silver plan in Tennessee charges a 50 percent coinsurance per *in-network* outpatient therapy visit.

- Some plans are designing their provider networks in a potentially discriminatory manner, such that patients with disabling conditions are unfairly and adversely impacted or are discouraged from choosing that issuer's health plan. Research recently published in the *Journal of the American Medical Association* found that 13 percent of the plans sampled that were sold through federally-facilitated exchanges completely lacked an in-network specialist within a 100-mile radius for at least one specialty. While rheumatologists, psychiatrists, and endocrinologists were most likely to be excluded from plan networks, the researchers found examples of plans where not a single cardiologist, neurologist or oncologist was available in-network within 100 miles.[2] Likewise, Avalere Health found in a study commissioned by the Association that, while inclusion of Comprehensive Stroke Centers (CSC) in networks varied widely across the 10 regions studied, 23 percent of QHPs did not include a single CSC in their network.[3] Other plans may be designing tiered networks such that specialty care is only available in the highest cost-sharing tier, with significant patient cost-sharing.

CMS indicates that it will assess compliance with the non-discrimination standard by using a number of tools, including outlier analysis on QHP cost-sharing and analyzing information provided by issuers in the Plans and Benefits Template. These types of reviews are helpful and necessary, but when reviewing QHPs for outliers based on estimated out-of-pocket costs, CMS should be sure to include facility fees and tiered-network cost-sharing as part of the analysis. Otherwise, the analysis will not give an accurate picture of actual patient cost-sharing.

Chapter 2, Section 11 – Prescription Drug Benefits

In the Letter, CMS outlines three types of formulary reviews that it will conduct in 2017 to ensure non-discrimination in QHP prescription benefit design: a formulary outlier review to identify plans with a high number of drugs subject to prior authorization and/or step therapy requirements; a clinical guideline-based review for nine medical conditions that will include a cost-sharing analysis; and a review of tier placement of prescription drugs for certain chronic and high-cost medical conditions.

We applaud this greater scrutiny because we have seen examples of plans with high cost-sharing and "adverse tiering" – the practice of placing all or most medicines for a specific condition on the highest cost-sharing tier. Some plans are charging a high co-insurance for prescription medications. Co-insurance as high as 40 or 50 percent put access to lifesaving medications out of reach for many people, particularly if they don't have other options for medications available on a lower formulary tier. Likewise, adverse tiering is discriminatory and needs to be prohibited. We note that CMS says that it "may" examine tier placement to determine whether an issuer is engaged in adverse tiering. In the final Letter, CMS should make it explicit that this practice is prohibited and that review of tier placement will occur.

Chapter 5, Section 4 – FFM Oversight of Agents and Brokers

[2] Dorner SC, Jacobs DB, and Sommers BD. Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act. *JAMA*. 2015; 314:1749-1750.
[3] Avalere Health, "Access to Comprehensive Stroke Centers & Specialty Physicians in Exchange Plans," September 26, 2014, available at: http://www.heart.org/idc/groups/public/@wcm/@adv/documents/downloadable/ucm_468318.pdf.

v. Compensation

It has been reported in the media recently that at least one major insurer, and potentially others, have stopped paying commissions to brokers for enrolling people in gold level QHPs. We are concerned that such a marketing tactic has the effect of discouraging the enrollment of individuals with significant health needs into higher metal tier plans. Because gold plans generally come with lower deductibles and out-of-pocket costs, they tend to attract older, sicker customers than bronze and silver plans. A number of states with state-based marketplaces, notably Colorado and Kentucky, have taken action to prohibit this practice. We urge CMS to also act through the Payment Notice or Letter to prohibit issuers from providing different compensation for products in different metal tiers.

Chapter 7, Section 4 – Summary of Benefits and Coverage

It is very important that critical improvements to the Summary of Benefits and Coverage (SBC) be effective for January 1, 2017, in order to ensure that essential information is provided to consumers. The Association has been a strong supporter of the SBC because of its significant value to patients and other consumers. Because of the ACA's requirements that the SBC be provided in a uniform manner in consumer-friendly language, in practical terms the SBC is the most important document consumers obtain to allow them to make "apples to apples" comparisons of health plans, select the plan that best meets their needs, and better understand their health insurance coverage. However, we are concerned that the SBC, while an improvement over other types of health insurance marketing materials and disclosures available to consumers, is not as helpful to consumers as it needs to be. In short, it is still not as consistent and accurate as it should be to ensure that consumers are able to make well-informed health plan choices.

To that end, we believe a narrow set of improvements should be made to the proposed template that was published alongside the proposed SBC rule in December 2014 and, because such changes would not be considered significant for purposes of the Paperwork Reduction Act, they could be implemented without delaying the January 1, 2017 effective date. The one change that should be made to the template itself (as opposed to the instructions) would be to add a question to the first page of the template: "Are there services covered before you meet your deductible?" The coverage of services before the deductible is a very important feature for consumers, and one on which plans offered through the Marketplace often vary. Under the existing template and instructions, however, this information has not been consistently available, and in many cases it has not been available at all. Marketplace enrollment assisters have observed that high deductibles can deter enrollment, and they have observed significant confusion among consumers about how cost-sharing charges work.

Four minor changes in the instructions would increase the value of the SBC for consumers and would better ensure that clear, accurate, and consistent information about covered benefits and cost-sharing charges is included in the SBC.

1. The "why this matters" column on the first page should inform consumers whether family deductibles and out-of-pocket limits are embedded or non-

embedded (aggregate). Consumers shopping for family coverage need to know how the deductible and out-of-pocket limits apply to individuals within the family in cases where an individual has met the individual deductible or out-of-pocket limit but the family has not met the family deductible or out-of-pocket limit. This is an issue that assisters have identified as a key source of confusion for consumers.

2. The instructions should be clearer that where networks contain multiple tiers, the issuer or plan must identify the cost-sharing for each tier independently. The current template only includes columns for in-network and out-of-network providers and the instructions are not entirely clear about the obligation of plans and issuers to add columns for additional tiers.

3. The instructions for the "limitations and exceptions column" for the common medical events pages give too much discretion to issuers and plans. The NAIC-recommended instructions said the column must indicate three pieces of vital information:

    - when a service category or a substantial portion of a service category is excluded from coverage (e.g., column should indicate "brand name drugs excluded" in health benefit plans that only cover generic drugs);
    - when cost sharing for covered in-network services does not count toward the out-of-pocket limit; and
    - limits on the number of visits or on specific dollar amounts payable under the health benefit plan and when prior authorization is required for services.

    CMS should incorporate this vital information into the SBC instructions.

4. The current instructions for the coverage examples provide that cost sharing for the diabetes example should be calculated assuming the enrollee is participating in a wellness program if one is available. Generally in the ACA rules--for example for determining affordability of employer coverage for premium tax credits or for the individual responsibility affordability exception—the assumption is that consumers are not participating in wellness programs. That should be the assumption for the coverage examples as well.

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Thank you again for the opportunity to share our comments on these issues related to network adequacy, discriminatory benefit design, and other important topics. If you have any questions, please feel free to contact Stephanie Mohl, Senior Government Relations Advisor, at Stephanie.Mohl@heart.org or 202-785-7909.

Sincerely,

Mark A. Creager, MD, FAHA
President