December 21, 2015

Secretary Burwell
Attention: CMS-9937-P
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Covered California comments on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; CMS-9937-P (RIN 0938-AS57); Section 155.220(C)(1) Direct Enrollment by Web-Based Entities

Dear Secretary Burwell,

Covered California is submitting comments in response to the proposed regulations CMS-9937. The comments in this letter refer to HHS' proposal to allow direct enrollment through web-based entities (Section 155.220(c)(1)). Covered California has also submitted comments on the following additional areas: standardizing health plan benefits, FFE user fee, and other issues.

In the Proposed Department of Health and Human Services Notice of Benefit and Payment Parameters for 2017, the Department of Health and Human Services' (HHS) seeks comments on a proposal to provide "eligibility determination" as a service to web-based entities ("WBEs") supporting enrollment in the Federally Facilitated Marketplace. The proposal delineates clear standards regarding the requirement that WBEs collect and display enrollment and subsidy eligibility information, but does not specify any standards or expectations relative to the consumer experience and support provided by WBEs for consumers related to the health plan they chose, the specific product (where health plans offer multiple products) or the level of coverage (e.g., bronze, silver) – collectively referred to in this comment letter as the "choice architecture."

As currently presented, the proposal appears to be relevant to both the Federally Facilitated Exchanges and to State-Based Marketplaces -- whether or not the State-Based Marketplaces are on the Federal Platform or even using their own IT and website infrastructure. While for the reasons noted below, we believe that as proposed the lack of standards regarding the choice architecture should be of great concern for consumers being served by the FFE -- if the

proposal were to relate to State-Based Marketplaces it would be a direct infringement on states' responsibilities and authority. In addition, the proposal as structured would potentially have significant negative effects on SBMs' efforts to ensure their consumers have a positive experience, attract and retain a good risk mix and work with the health plans they contract with to ensure the best use of administrative fees collected as part of the premium but paid by carriers to agents -- including web-based entities -- is well spent and follows SBMs' policies with regard to sales by licensed agents to consumers in their state.

Covered California supports the use of licensed agents to promote enrollment, but does so with clearly delineated standards of certification, training and use of the Covered California name and logo. Any policy related to web-based entities that encompassed more than the FFE would usurp SBM's strategic and tactical responsibility of marketing.

Covered California believes that having clear standards and expectations of WBEs' choice architecture is of critical importance to ensuring consumers are well served. In the absence of clear standards, consumers may experience confusing displays of health plan options, make less optimal plan and product choices, be routed to off-exchange products, or not get appropriate in-person support when it is needed. Having poor or confusing plan choice display runs the risk of resulting in smaller enrollment and a worse risk pool.

While Covered California does not currently partner directly with web-based entities in the way that the FFM does, many WBEs sell Covered California insurance as Certified Insurance Agents. In addition, Covered California has done extensive review of the advantages of expanding on-line sales by agents – which is what WBEs provide. Covered California is actively considering options to expand our relationship with WBEs.

Covered California currently deploys a multi-pronged sales strategy to attract and enroll Californians across our diverse and large state. Entering the third coverage year, Covered California has enrolled over 2 million individuals cumulatively, an accomplishment that is built upon strong relationships with Certified Insurance Agents, Navigators, and other Enrollment Assisters, as well as robust choice architecture tools that help enrollees make informed health plan selections.

Covered California provides the following technical assistance for HHS to consider. First, HHS should not promulgate policies with regard to WBEs in any way that impacts SBMs. One of the core responsibilities and benefits of being a SBM is to have the locally anchored control over marketing and outreach efforts. The manner with which a SBM chooses to structure its relationship with WBEs is a critical part of its channel strategy for promoting enrollment, and there is no rationale for HHS intruding on states' marketing and outreach strategies by making WBE policy decisions that imposing strategies that may make sense for the FFE on SBMs that may not be similarly situated.

To the extent HHS allows for WBEs working in FFE states to process end-to-end enrollment, it should set clearly articulated high standards for the consumer choice architecture to be provided by WBEs and qualified health plan (QHP) issuers via direct enrollment vendor arrangements. There is considerable variation in WBEs' consumer plan choice experiences today and many services do not apply proven elements of plan choice decision support. For example, many web broker services do not offer choice architecture features that Covered California has found to be important, including:

a) Eliciting user preferences or needs;

b) Matching users to plans based on their needs or preferences (e.g., the default product listing is based on lowest premium product);
c) Offer a consolidated all-plan provider directory;
d) Generate total costs estimates – including out-of-pocket costs -- for each QHP; or
e) Educate users about the pros and cons of high deductible, HSA products.

HHS should consider WBE services in the context of the value they add by increasing enrollment and reducing costs to the FFM call center – value that is paid for out of the commission payment made by contracted plans. In this context, we present comments in four areas: 1) the critical importance of choice architecture; 2) staffing to support web-based entity activities; 3) the scope of products in the plan comparison tools for issuer direct plan enrollment; and 4) the validation of WBEs' and QHPs' plan choice and decision support services.

1. Plan Choice Decision Support Elements – Choice Architecture

The choice architecture is an absolutely critical part of consumers' experience when they are enrolling in coverage. That architecture can determine the extent to which a consumer picks the "best value plan" for their situation, maximizes their use of the federal Advanced Premium Tax Credit and Cost-Sharing subsidies, and how effectively the consumer is educated through their enrollment to be a more educated user of insurance -- which can have direct implications on fostering better retention, a vital component to ensuring a good risk mix over time. Given these concerns, if HHS establishes a direct enrollment strategy -- and even in the absence of such a policy, where consumers' plan-choices are not done through Healthcare.gov -- HHS should consider requiring that WBE vendor products include the following elements:

- Elicit user preferences/needs – at a minimum, query user about interests in access to a particular provider and/or comparing provider networks
- User-match-to-plans algorithm – prohibit the use of "lowest premium cost" plan sort default; require that one or more user preferences (e.g., provider in-network, out-of-pocket cost estimate, formulary medication, HSA interest) are incorporated into the plan sort default
- Default product sort displays Cost Sharing Reduction (CSR) products for eligible users
- Provide a consolidated, all-plan provider directory to easily search for in-network providers
- Provide a consolidated, all-plan formulary function to easily search for medication coverage
- Present in standardized and prominent manner QHP quality ratings that include the QHP product global rating and enrollee experience rating
- Out-of-pocket and total cost estimator – including premium paid after APTC and out-of-pocket – to provide an estimate of user's cost share for each QHP based on the consumer's likely utilization
- Renewal experience that includes comparing currently enrolled QHP with alternatives

2. Staffing to Support Web-Based Entity Enrollment and Retention

HHS should specify that approved WBEs should commit to specific staffing and/or service level thresholds and standards such that consumers using the web service can access trained and compentent online chat support, free in–person assistance, and telephone support. To achieve

a streamlined enrollment experience, consumers who enroll through a WBE should be able to upload documents to resolve data inconsistencies relating to their eligibility and the WBE should be responsible for following-up to resolve such inconsistencies. Consumers may also have to upload or submit verifying documents for special enrollment qualifying life events. In order to support both enrollment and retention, WBEs should possess the capacity for and there should be the expectation that they fully support applicants and enrollees. One of the valid rationale's for using WBEs is to take workload and expense off of the federal or state-based call center. This value proposition requires the FFE to put clear standards in place.

3. Scope of Products in Plan Comparison for QHP Issuer Direct Enrollment

HHS should prohibit the direct enrollment vendor from presenting only off-Exchange products to non-subsidy eligible users unless the user opts-out and requests consideration of off-Exchange products only.

Issuer-specific direct enrollment vendors should be required to present all Marketplace plans for a given geography and not limit the QHPs to issuer-only products unless the user opts-out and requests consideration of only the QHP issuer's health plans. The provisions and rules for when a consumer can "opt-out" need to be clearly defined to be sure the consumer understands the potential availability of other plan options that may be lower cost.

4. Validation of WBE/QHPs' Plan Choice Decision Support Service

HHS should adopt processes to ensure that direct enrollment vendors' plan choice decision support and WBE's service performs well by ensuring consumers are making an informed health plan choice. Among the processes that HHS should adopt are:

a. Check-list and review of required plan choice elements

HHS should adopt a "plan choice required elements" template to be completed by vendors seeking qualification. The direct enrollment vendor also should provide login credentials that HHS can use to directly validate the vendor's plan choice displays, tools, and other elements of their application.

b. Plan choice validation testing

HHS should adopt a "seal of approval" recognition standard that qualified direct enrollment vendors can use in their branding. The "seal of approval" should be awarded for those direct enrollment vendors whose plan choice applications have been validated using HHS approved or sponsored software. In the validation test, a sample of simulated consumers are entered into the enrollment vendor's application and hypothetical plan choices are made; these plan choices are evaluated against expected results based on a reference set of "informed plan choices" for those simulated consumers whose demographics are representative of the Marketplace enrollees.

c. Consumer plan choice experience monitoring data

HHS should adopt a plan choice experience reporting template to be completed and submitted at periodic intervals by the direct enrollment vendor. The plan choice template should capture two dimensions of plan choice experience: i) consumer plan choice experience to include HHS supplied standard questions (e.g., pop-up survey at close of session), and ii) web analytics that capture important aspects of the experience like the

median session time, use of key information elements, frequency of abandoned sessions by exit page, etc.

Thank you and please contact me if you have any questions.

Sincerely,

Peter V. Lee
Executive Director

CC: Covered California Board of Directors