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Families USA is a national nonprofit, nonpartisan organization dedicated to the achievement of high-quality, affordable health coverage for all. We are writing on behalf of health care consumers to comment on the proposed rule for the Establishment of Exchanges and Qualified Health Plans, authorized by Title I of the Patient Protection and Affordable Care Act (ACA).

Exchanges are the centerpiece of the Affordable Care Act. They will serve as the portal through which millions of Americans will obtain health insurance coverage starting in 2014. We therefore strongly support the implementation of this proposed rule. However, our following comments urge enhancements to the rule to ensure that the policies and operations of Exchanges reflect consumer interests and needs.

§155.100- Establishment of State Exchange

a. General requirements

General Principles for a Partnership Exchange
Families USA agrees with the statement in the preamble that it may be advantageous for states to partner with the federal government on certain Exchange functions to reduce redundancy, promote efficiency, and address tight implementation timelines. We recognize that HHS, in proposing the partnership model, is trying to be responsive to states that want additional flexibility and options for establishing an Exchange within the required timeframe. However, we note that the already law gives states that need more time to set up an Exchange the option to coordinate with HHS and move from a federally operated to a state Exchange after 2014. Further, a federally facilitated Exchange can collaborate with the state on certain functions, such as by contracting with a state Medicaid agency, when it will benefit consumers and enhance the smooth and efficient operation of the Exchange. HHS should consider other models of providing federal assistance, including technical systems and advice, for states that opt to set up their own Exchanges but need help with some functions.

If a formal partnership model (as described by HHS in a Powerpoint and a healthcare.gov factsheet from September 19, 2011) is provided as an option for Exchange establishment, we believe strongly that any partnership Exchanges must have consumer interests at their core. To

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accomplish this will require a clear delineation of responsibilities between the federal and state governments and the development of strong consumer protections to ensure continuous access to care whenever there is a partnership for performing Exchange functions. We believe that information on the partnership Exchange model released by HHS on September 19, 2011 reflects these critical principles and indicates that HHS envisions partnership models that ensure a seamless coverage system for consumers and a high level of accountability for meeting all federal standards.

The new information specifies three discrete partnership options for states. States may partner with HHS on:

1. **"Plan Management"** States can operate plan selection, collect and analyze plan rate and benefit information, perform ongoing issuer account management, conduct plan monitoring and oversight, and collect and analyze data for plan quality. HHS will coordinate with states regarding plan oversight, including consumer complaints and issues with enrollment reconciliation. Where appropriate, HHS will help to ensure that Exchanges meet all of the required standards so consumers have access to a range of high quality plan options.

2. **"Consumer Assistance"** States can operate in-person consumer assistance, manage the Navigator program, and conduct outreach and education. Other consumer assistance functions including call center operations, managing the consumer website, and written correspondence with consumers to support eligibility and enrollment would be operated by HHS.

3. **Plan Management and State Consumer Assistance** States can partner on both of these functions.

Exchange functions other than selected consumer assistance or plan management functions will be performed by HHS under these options.

We believe that providing only discrete partnership options is appropriate. However, we have a recommendation regarding the Consumer Assistance partnership: We believe that if HHS operates a state's Exchange call center and Exchange website, these functions must still be closely connected to state agencies and organizations. For example, the call center must have the capacity to do three-way calls with the state Medicaid agency, the state insurance department, and any other state consumer assistance resources. This may be necessary in many situations, such as when non-MAGI Medicaid-eligible individuals contact the call center or when a caller has concerns about health plan practices. There must be memorandums of understanding between HHS and these agencies to ensure that consumer problems are fully addressed in a timely manner. An HHS-operated Exchange website must also be closely connected to the state, with the capacity to connect visitors to state resources such as consumer assistance programs and state-funded coverage programs. Therefore, we recommend that under a Consumer Assistance partnership model, HHS-operated Exchange call centers and websites be required to have a formal relationship with the state.

The information released by HHS in September regarding partnership models clarifies that the

federal government is responsible for ensuring that a partnership Exchange is ACA compliant. If more than one entity (i.e., both the state and federal governments) were accountable for an Exchange's compliance, enforcement roles would be unclear. Consumers would not know where to turn with questions or grievances, and accountability for consumer problems could be segmented according to which entity oversees a given Exchange function. In this situation, consumers could end up caught in the middle between the federal and state governments as the entities dispute their roles and responsibilities.

For these reasons, very clear lines of authority and accountability must be articulated for permitted partnership models. It is critical that in any partnership, one entity is responsible for overall Exchange compliance with the ACA and corresponding rules. Further, in any partnership, there must be a place where consumers, Navigators, and other stakeholders can report problems, whether they are individual or systematic, and receive a prompt response. A clearly identified entity must be responsible for addressing problems and there must be standards in place to ensure that it does so promptly. To ensure ACA-compliance, HHS should have the authority and a plan to intervene and resolve problems if a partnership Exchange fails to perform its required duties.

Also, plans for partnership Exchanges must be publicly available and contain all information required of a state Exchange Plan, along with a clear delineation of which party is responsible for carrying out specific functions. The public should have opportunities to weigh in on the plan before it is implemented to ensure that it adequately reflects the needs of consumers in the state. In addition, partnership Exchanges should undergo an annual review to ensure that they are functioning and serving consumers well. Such a review should assess partnership Exchanges based on specific performance measures, including coordination between the federal and state governments and response times and success rate for answering and addressing consumer complaints. The review should be public and open to comment.

Finally, the final rule should articulate how partnership Exchanges will be financed. The information released by HHS in September explains that the federal government can collect assessments on carriers for a potential federal Exchange funding source. Further, it explains that states can use establishment grant funding to develop state-operated functions in a partnership model. However, the information does not address how states will finance ongoing operations of the functions they develop and manage in a partnership Exchange beyond the year 2014. The regulations should define a mechanism to provide sufficient financial support for state-operated functions under a partnership model that could include the distribution of an appropriate portion of carrier assessments collected by the federal government to the state to finance state-run Exchange operations.

Recommendation: Only a limited number of discrete Exchange partnership models should be permitted. Clear lines of authority and accountability must be articulated in partnership Exchanges. One entity must be responsible for overall Exchange compliance with the ACA in any partnership and HHS must have the authority to intervene if a partnership Exchange is not fulfilling its duties. Rules should codify that in any partnership there must be a place where consumer problems can be reported so that a quick response and solution is delivered by the clearly identified responsible entity. A public input period must be

required for all partnership plans and models. Under a Consumer Assistance partnership as described by HHS, we recommend that HHS be required to have a formal relationship with the state in the operation of the Exchange call center and website. Finally, the final rule should describe how partnership Exchanges will be financed.

Eligibility and Enrollment in a Partnership Exchange

The overarching goal of an Exchange must be to provide a seamless, one-stop shop for the consumer, regardless of whether the Exchange is run by the state, the federal government, or a partnership of the two. Consumers must be able to find out whether they are eligible for Medicaid, CHIP, premium tax credits and cost-sharing reductions for QHPs, and Basic Health or any other applicable programs; to obtain comparative information on health plans; and to enroll in coverage through the application method they prefer (online, by phone, by mail/fax, or in person). If Exchange functions are operated by separate entities, this separation must be entirely invisible and seamless for the consumer.

Discrete partnership options like HHS proposes will prevent arbitrary divisions of authority for Exchange functions that could jeopardize the ability of Exchanges to serve as seamless, one-stop-shops for coverage. We support that the presentation to State Exchange Grantees on September 19-20 indicates that dividing eligibility and enrollment functions of an Exchange between federal and state governments will not be permitted, as this would endanger the seamless, no-wrong-door system of the Exchange and would conflict with the goals of increasing efficiency and reducing redundancy. Families USA also supports HHS's proposed requirement that states entering into partnership Exchanges must agree under the terms of their grants to ensure insurance department, Medicaid, and CHIP cooperation to coordinate business processes, systems, data/information, and enforcement. We also recommend that "enrollment" be added to this list of functions that need to be coordinated. We strongly support the requirement that states accept HHS's eligibility determinations in instances where HHS will be responsible for determining eligibility for qualified health plans, tax credits, cost-sharing reductions, and Medicaid and CHIP eligibility based on modified adjusted gross income (MAGI), and we recommend that HHS outlines how it will enforce this requirement in the final rule. Since in some states, people who are not eligible for Medicaid through MAGI eligibility categories may be eligible through non-MAGI categories or may be eligible for state-funded programs, HHS must work with states to ensure that partnership or federally operated Exchanges seamlessly connect individuals to state coverage programs. Further, the final rule should codify that if a dispute arises between a state and the federal government regarding an individual's eligibility for Medicaid or premium subsidies, the consumer must be held harmless and enrolled in coverage while the entities resolve the dispute.

Recommendation: The final rule should codify that states opting for partnership Exchanges must ensure insurance department, Medicaid, and CHIP cooperation to coordinate business processes, systems, data/information, and enrollment. HHS should outline how it will enforce these requirements, and the final rule should codify that if a dispute arises between a state and the federal government regarding an individual's eligibility for Medicaid or premium subsidies, the consumer must be held harmless and enrolled in coverage while the entities resolve the dispute. HHS should ensure that it can adequately link individuals who are eligible for Medicaid through non-MAGI categories or

for state-funded programs to coverage. The final rule should codify that eligibility and enrollment functions of an Exchange may not be bifurcated between the federal and state government.

b. Eligible Exchange entities

The proposed rule appropriately codifies the option for states to establish an Exchange as a governmental agency (including an independent public agency, as described in the preamble) or as a non-profit entity. We agree with the sentiment expressed in the preamble that states should consider the limitations of a non-profit Exchange, including that "non-profit entities may face limitations performing functions that are typically governmental in nature." We also have concerns regarding the ability to hold non-profits accountable, and therefore believe that HHS should generally encourage states to pursue quasi-governmental or governmental Exchanges.

§155.105- Approval of a State Exchange

Families USA supports the creation of a state Exchange approval process that includes the submission of a state Exchange Plan in a form and manner specified by HHS. **Our comments on the state Exchange approval process reflect the common principles of many consumer advocacy groups, but include Families USA's unique recommendations.**

b. State Exchange approval standards

The rule proposes that, in order for a state to be approved to operate an Exchange, the entire geographic area of the state must be covered "by one or more Exchanges." In accordance with the statute, and as articulated in the preamble, each Exchange in a state must operate in a geographically distinct area and no area may be served by more than one Exchange. This is necessary to reduce confusion for consumers and to ensure that Exchanges operate as efficiently as possible.

The language of the proposed rule must be modified in this section so that it is clear that in states with multiple Exchanges, each Exchange must serve a distinct geographic area. HHS should also consider a requirement that the distinct geographic areas be consistent with premium rating areas in the state as determined under section 2701(a)(2) of the Public Health Service Act, added by section 1201 of the Affordable Care Act. Families USA supports the preamble's statement that states with more than one Exchange should work to ensure that consumers understand which Exchange they will receive coverage from.

Recommendation: In the final rule, HHS should modify §155.105(b)(4) to read: "The entire geographic area of the State is covered by one or more State Exchanges, each serving a geographically distinct area."

c. State Exchange approval process

Families USA supports the preamble's statement that the submission of an Exchange Plan will also likely require copies of any agreements with contractors that will be carrying out Exchange functions in accordance with Section 155.110 of the proposed rule. We believe that the submission of such agreements should be required for Exchange approval.

Further, we believe that state Exchange Plans should be developed with stakeholder input, as required for the development of Exchanges under the ACA. State Exchange Plans should be transparent and available to the public (with the exception of information that is truly proprietary) and the public should be able to comment on them. HHS should ensure that states' Exchange Plans are subject to a comment period before they are approved, either by releasing the plans and taking comments at the federal level or by requiring states to make Exchange Plans in their final form available to the public and accept comments before they are submitted to HHS.

We recommend that HHS clarify as soon as possible when the additional guidance/ "template" for Exchange Plan requirements (mentioned in the preamble) will be released. Such a template will be very helpful to States moving forward on Exchange implementation, as it will allow them to fully understand what they must accomplish in order to obtain approval to operate an Exchange. We encourage HHS to make the template as similar as possible to what the actual Exchange Plan application will look like in its final form.

Finally, we support the requirement that a state Exchange must demonstrate operational readiness through a readiness assessment conducted by HHS, coordinated with the grants monitoring process under the state planning and establishment grants. As we recommend for the forthcoming guidance on Exchange Plan requirements, the HHS should specify as soon as possible when guidance on the structure for and schedule of these assessments will be available.

Recommendation: The final rule should require states to submit any agreements with contractors that will be carrying out Exchange functions with their Exchange Plan applications. It should also require a public comment period for state Exchange Plans before they are approved.

d. State Exchange Approval

Families USA supports the proposal in the preamble that HHS review state Exchange Plans within a 90-day window, after which HHS may approve, deny, or request comment from the state on the plan (with another 90 days for HHS to review additional information from the state if comment was received). We believe that this process should be incorporated into the final rule. The final rule should also then specify the due date for state Exchange Plans. It would appear that in order to accommodate this approval process timeline and meet the January 1, 2013 deadline for issuing written or conditional approval of state Exchanges, the deadline for state Exchange Plan submission to HHS would be June 2012. This fast-approaching deadline highlights the need for state Exchange Plan templates and guidance on the structure and schedule of readiness assessments to be available from HHS as soon as possible.

Regarding conditional approval of Exchanges, we recommend that the final rule clarify that states receiving conditional approval must not just have an Exchange operational by January 1, 2014, but be able to operationalize enrollment into certified QHPs starting October 1, 2013. HHS, in granting conditional approval to a state, should establish interim deadlines during 2013 that will assure that an Exchange is fully operational by the start of the initial open enrollment period.

Finally, the preamble refers to the potential for conditional approval of a state Exchange to be revoked. The final rule should outline the latest date at which conditional approval can be revoked in order for the federal government to have adequate time to implement a fully federally facilitated Exchange in the state in time for October 1, 2013 enrollment into QHPs and a coverage effective date of January 1, 2014.

Recommendation: The final rule should clarify that states receiving conditional approval must be able to operationalize enrollment into certified QHPs starting October 1, 2013. It should also require the establishment of interim deadlines for completing Exchange function development during 2013 for states receiving conditional approval. Finally, it should clarify the latest date at which conditional approval of a State Exchange can be revoked to ensure adequate time for the development of a federally facilitated Exchange.

e. Significant changes to Exchange Plan

Families USA supports the requirement that a state must notify HHS in writing before making a significant change to its Exchange Plan and that such changes must be approved by HHS before their implementation. Utilizing the State Plan Amendment process in place for Medicaid and CHIP, as proposed in the preamble, is an approach to this process that we support. We recommend that the final rule modify the definition of a "significant change" so that all changes that are not de minimus changes be considered significant, and that content of the Exchange Plan template be the basis for this standard. Under this definition, changes to the content of the Exchange Plan would constitute a "significant change." Further, in addition to the Exchange function changes provided as examples of "significant changes" in the preamble, we recommend that the final rule names changes to the Navigator program and changes to SHOP Exchange as well. Finally, "significant changes" to an Exchange Plan should be subject to transparent public notification and comment, modeled on the processes that exist in Medicaid.

The preamble states that, by establishing an ongoing dialogue with each state, HHS will be able to ensure that each Exchange is operating in compliance with federal requirements. However, more formal oversight of state Exchange compliance with federal requirements is necessary. State Exchanges will be developed with federal grant dollars and will provide individual and small group coverage that is subsidized by federal tax credits. Therefore, the federal government must consistently hold Exchanges accountable for complying with federal law.

The final rule or future guidance should outline how HHS will perform ongoing, regular monitoring to ensure that states are complying with federal Exchange requirements. This should include a plan for how consumers and stakeholders can report state non-compliance to HHS. As part of establishing a process to address complaints about a state Exchange, HHS should ensure that consumers and stakeholders are aware of the ability to make complaints to the federal government. Further, regulations should codify what HHS will do if a state is found to be out of compliance with federal requirements. In such a situation, a state Exchange should be given a limited amount of time to correct its problems. If it does not come into compliance with federal requirements within such a time period, the federal government must implement sanctions or prepare to transition that Exchange to a federally facilitated Exchange. There must also be a system in place to immediately allow consumers to apply to the federal government for advance

premium tax credits and Medicaid if a state Exchange is not processing applications in a timely manner.

Recommendation: The final rule should adopt a process for approving significant changes to Exchange Plans that is similar to the process used for Medicaid and CHIP State Plan Amendments. It should define "significant changes" as all changes that are not de minimus changes, based on whether the content subject to change is included in the state's Exchange Plan. Changes to the Navigator program and changes to the SHOP Exchange should be added as examples of significant changes. The final rule or future guidance should outline how HHS will perform consistent monitoring of state Exchange compliance with federal requirements, including with a response system for consumer and stakeholder complaints. It should also describe the process that the federal government will undertake when a state Exchange is found to be non-compliant.

f. HHS operation of an Exchange

The proposed rule includes few details about HHS operation of an Exchange. We agree that a federally operated Exchange should have to meet the minimum standards for a state-operated Exchange in terms of performing the functions required by law. The final rule or future rulemaking must go beyond this basic description to address a number of important details about how a federally operated Exchange will work. With state-operated Exchanges, the proposed rule leaves many decisions about how to carry out specific requirements open to state discretion. It is therefore difficult to determine how a federally operated Exchange will meet these requirements and whether decisions about such details will differ from state to state or be consistent in all places with a federally facilitated Exchange. If information about an HHS-operated Exchange were available, a federal Exchange could serve as an important benchmark or model that states setting up their own Exchanges could benefit from as they make policy and operational decisions.

A federally facilitated Exchange must adequately consult with the public (particularly residents of the state where it will operate) on decisions regarding how it will carry out Exchange functions. A federally facilitated Exchange should be required to create a document like an Exchange Plan for state-operated Exchanges to share with the public for comment. The federally facilitated Exchange should be subject to a public review process for significant changes, as well. In addition, a federally facilitated Exchange should be subject to the same requirements regarding contracting that State Exchanges are subject to under section 155.110 of the proposed rule, and the same requirements regarding non-discrimination under section 155.120, where applicable.

Recommendations: The final rule should outline the implementation process and structure of a federally facilitated Exchange. In particular, it should describe whether the structure of such an Exchange will differ from state to state and how a federally developed and operated Exchange will meet required standards and operationalize required functions. A federally facilitated Exchange should have a plan for public review just as state Exchanges will and should have a transparent process with a comment period for any significant changes to the Exchange plan. A federally facilitated Exchange should comply with the same contracting and nondiscrimination requirements (section 155.110 and 155.120,

respectively) as state Exchanges, where applicable.

§155.106- Election to operate an Exchange after 2014

a. Election to operate an Exchange after 2014

Families USA supports the requirement that states seeking approval to operate an Exchange after January 1, 2013 must comply with the requirements for submitting an Exchange Plan, undergoing a readiness assessment, and meeting the other standards described in Section 155.105 of the proposed rule. We also support the requirement that a state transitioning to run its own Exchange must have in effect an approved or conditionally approved Exchange Plan and operational readiness assessment at least 12 months prior to the effective date of coverage. We recommend that the final rule clarify that a transitioning Exchange is required to begin open enrollment on October 1 of the year before coverage is effective (and therefore must have QHP certification completed before that date).

Under a joint HHS-state plan to facilitate the transition from a federal Exchange to a state Exchange, it is critical that stakeholders—particularly consumers—have input into the process. Consumers' continuity of coverage and access to needed care must not be jeopardized in a transition from a federal to a state Exchange. The preamble refers to the possibility that QHPs that were certified in the federal Exchange may not be certified in the newly implemented state Exchange. It is critical that transitioning states strongly consider enrollee input during the plan certification process to ensure that they are aware of which existing QHPs are meeting consumers' needs. The HHS-state joint transition plan must formally consider consumer and stakeholder input.

Further, a state that takes over operations of an Exchange should have to demonstrate (either as part of its Exchange Plan or its transition plan developed jointly with HHS) how it will inform and educate consumers about the changes to the Exchange that will result from the transition. Changes should be implemented with minimum harm and inconvenience to consumers (for example, by ensuring that consumers are automatically redirected from an old website to a new one if the website changes, or that call center numbers remain the same). To the extent that this is not possible, the state must ensure that consumers are aware of changes and that protections are in place to prevent consumers from falling through the cracks. As part of its Exchange Plan or transition plan, a state should be required to articulate how it will minimize harm and inconvenience to consumers caused by the transition.

Finally, states electing to transition to a state-run Exchange should not be allowed to weaken the already established Exchange. Consumers should have guaranteed access to QHPs at similar or better levels of affordability, covered benefits, and administrative simplicity. The HHS-state transition plan should include future measurement standards to ensure that the new state-run Exchange demonstrates similar or better insured rates and affordability and quality of coverage.

Recommendation: The final rule should clarify that newly state-run Exchanges must begin open enrollment on October 1 of the year prior to when coverage will be effective. The joint HHS-state transition plan should formally include and consider consumer input. States

should be required to outline a plan for educating consumers about changes that will result from a state-run Exchange and a plan for ensuring minimal harm to consumers in the transition process in order to receive approval to run an Exchange. States should be required to demonstrate that the state-run Exchange will have similar or better levels of insured rates, affordability, covered benefits, and administrative simplicity.

b. Transition process for State Exchanges that cease operations

Families USA supports the requirement that a state determining it will no longer operate its Exchange after January 1, 2014 must notify HHS 12 months prior to ceasing its operations. However, we are wondering what will occur if a state fails to comply with this requirement. How will a state be penalized for noncompliance with the 12-month requirement? The preamble states that HHS estimates needing 12 months to establish a federally-facilitated Exchange in a state, but will HHS have the capacity to take over Exchange functions more rapidly in a situation of state noncompliance? We recommend that HHS develop a "back-up plan" that seeks to minimize problems for consumers, particularly gaps in coverage, in the event that a state ceases to operate an Exchange without following the requirement for 12-months advanced notice. For example, HHS could arrange for consumers to remain in their existing qualified health plans, at least on an interim basis, despite the fact that the Exchange that certified those plans is no longer operating.

Families USA also supports the requirement that a transition from a state to a federal Exchange, like the reverse transition, must have a joint HHS-state transition plan. We recommend that the transition process from a state to federal Exchange meet the same transition requirements we recommend for section 155.106(a). Namely, the newly federally run Exchange must have an open enrollment period beginning on October 1 of the year prior to when coverage is effective; the joint HHS-state transition plan should formally include and consider consumer and stakeholder input; the joint HHS-state transition plan must outline a process for educating consumers about changes that will result from a federally-run Exchange and for ensuring minimal inconvenience and harm to consumers in the transition process; and the newly federally run Exchange should have similar or better insured rates, coverage affordability, covered benefits, and administrative simplicity compared to the previously state-run Exchange.

Similar to our concern regarding state noncompliance with the 12-months advanced notice requirement, we are concerned that some states may not actively engage in the HHS-state transition planning process. We wonder how HHS will enforce this requirement and whether HHS will have a back-up plan to ensure that consumers have continuous coverage and access to needed care in the event that a state ceasing Exchange operations does not comply with the requirement to develop a joint HHS-state transition plan.

Recommendation: HHS should develop enforcement mechanisms for ensuring that states ceasing Exchange operations comply with requirements to provide 12 months advance notice to HHS and develop a joint HHS-state Exchange transition plan. HHS should have a "back-up plan" for the event that a state does not comply with these requirements. The final rule should clarify that a newly federally run Exchange must have an open enrollment period beginning on October 1 of the year prior to when coverage is effective; the joint HHS-state transition plan must formally include and consider consumer input; the joint

HHS-state transition plan must outline a process for educating consumers about changes that will result from a federally run Exchange and for ensuring harm to consumers; and the newly federally run Exchange must have similar or better insured rates, coverage affordability, covered benefits, and administrative simplicity compared to the previously state-run Exchange.

§155.110- Entities eligible to carry out Exchange functions

a. Eligible contracting entities

Families USA strongly supports Section 155.110(a)(2), which allows the Exchange to contract with Medicaid agencies. State Medicaid agencies have the technical expertise needed to address eligibility and enrollment issues of low-income populations. This expertise will be essential in helping enroll low- and middle-income Americans in appropriate subsidized coverage options.

HHS seeks comment on Exchange functions that outside entities could perform. We support the requirement that contractors not be health insurance issuers, but believe that it still remains important to consider the financial interests of outside entities and the potential for mismanagement of consumers' personal information when determining what role outside contracting entities should play in performing Exchange duties. For example, a web-based entity could use the personal information collected to steer healthy applicants to plans outside of the Exchange. The issue of having a conflicted party perform Exchange functions is not a theoretical concern. In California and likely in other states, the website ehealthinsurance.com – a licensed health insurance broker – is expressing its interest in helping to operate Exchanges. We recommend that contractors, vendors, and other outside entities that are under consideration to contract with an Exchange be required to disclose any potential conflicts of interest to the contracting Exchange entity and on a public website. Further, we recommend that the Exchange be required to issue an independent finding of any potential conflict of interest and disclose this on a public website. If there is a finding of conflict of interest, then there should be a rebuttable presumption that no contract will proceed. In order to overcome this presumption, the Exchange should be required to present a written justification on a public website describing in detail why the contractor or vendor is uniquely able to perform the contract, why other contractors or vendors without a conflict of interest are not available, and/or why the specific contract would best serve the interests of consumers in the Exchange.

Further, we recommend that outside entities not be allowed to perform functions that are "inherently governmental." Many functions of the Exchange are "inherently governmental," as defined in OMB Circular No. A-76 (revised 2003).[1] The Guidance states that:

> "An inherently governmental activity is an activity that is so intimately related to the public interest as to mandate performance by government personnel. These activities require the exercise of substantial discretion in applying government authority and/or in making decisions for the government. Inherently governmental activities normally fall into two categories: the exercise of sovereign government authority or the establishment of procedures and processes related to the oversight of monetary transactions or

entitlements."

Because Exchange decisions will determine, for example, whether low- and moderate-income individuals and families obtain federally funded premium tax credits and cost-sharing reductions for which they are eligible and, thus, whether they can obtain health coverage, it is essential that there be strong public accountability for how these functions are performed. Whether eligibility functions are performed well or poorly would not only affect consumers and small businesses, but also taxpayers who would be on the hook to pay wasteful costs if eligibility systems do not function efficiently and accurately. We believe that the best way to ensure accountability for these functions is through the use of governmental staff who will carry them without bias or conflicts of interest.

However, it may be appropriate to delegate some functions of the Exchange to a private contractor. In particular, mechanical functions such as data processing and other IT requirements could be considered for private sector contracting in areas where competitive markets exist and for which performance can be readily monitored.

Families USA strongly supports the provision of the rule that explains that "an Exchange remains responsible for ensuring that all Federal requirements related to contracted functions are met." Regardless of whether some functions are performed by a contractor, a governmental or quasi-governmental body (depending on an Exchange's governance structure) must retain oversight authority and accountability for all Exchange functions. For example, if an Exchange contracts with any vendors to ascertain plan compliance with QHP standards, the governmental or quasi-governmental body must still retain ultimate oversight and the government must maintain regulatory authority over the plans. In eligibility and enrollment systems, the government must be the keeper of private information and be accountable for its security and the government must be accountable for timely eligibility and enrollment processes that preserve due process rights. If something goes wrong with a contractor's performance, a governmental entity must promptly step in to remedy the problem for enrollees. Further, states and HHS should use their enforcement authority to ensure transparency in contracting, such as by verifying that contracted work has not been inappropriately subcontracted.

Recommendation: The final rule should reference OMB Circular No. A-76 (revised 2003) as model guidance regarding what Exchange functions government agencies and employees should perform and what functions may be contracted out under the supervision of a governmental entity. The final rule should include conflict of interest and privacy provisions to ensure that the Exchange, HHS, and the public know of any vendor's potential financial conflicts and that such conflicts are prevented or minimized, and to protect the personal data of consumers.

b. Responsibility

Families USA supports the requirement in Section 155.110(b) that the Exchange be held responsible for ensuring that all federal requirements for an Exchange are met, regardless of whether or not functions have been contracted out. Having one centralized entity responsible for Exchange duties will help ensure accountability for responding to consumer complaints and

concerns. In addition, federal enforcement of state compliance with the Affordable Care Act will be easier when one centralized entity is held accountable.

c. Governing board structure

Families USA strongly supports Section 155.110(c)(1) of the proposed rule, which requires that an Exchange governing board must be "administered under a formal, publicly-adopted operating charter or by-laws." This requirement will provide accountability by requiring the governing board to explain what decisions are up to the governing board and what procedures the board must follow for decision-making purposes. The operating charter or by-laws should also address the procedures by which any interested parties can offer input to the Exchange board.

Families USA supports Section 155.110(c)(2), which requires that regular governing board meetings be open to the public and announced in advance. Families USA believes that the public governing board meetings should be announced far enough in advance that the public can adequately plan to attend. On the other hand, we want to allow for public meetings when an urgent issue arises. Therefore, we recommend that HHS require Exchanges to set advance notice timeframe requirements for public meetings, including notice requirements for emergency public meetings. We want to ensure that notice of the meetings is distributed widely via a public website, email, and non-electronic formats. For example, public meeting notices should be posted in local media with wide circulation. We also recommend that HHS set public meeting standards such that all Exchange governing board meetings must be public unless there is a justifiable reason for why a meeting should not be public, such as the need for confidentiality to discuss proprietary information. We fear that without more specific minimum public meeting standards, Exchanges could choose to hold only a small share of governing board meetings in public.

We support that Section 155.110(c)(3) of the proposed rule seeks to ensure that the Exchange governing board "[r]epresents consumer interests" and limits the number of conflicted parties represented so that they do not constitute a majority of the board. However, we recommend that the final rule a) explicitly require that representatives of consumer interests must hold seats on the Exchange board and b) include stronger conflict of interest requirements, as explained in detail below.

Families USA urges that Section 155.110(c) of the final rule require that multiple representatives of consumer interests, including consumers, must hold seats on the Exchange governing board. In order to ensure that the Exchange is truly functioning in the best interests of those who will be using it to purchase coverage, there must be representatives of consumer interests on the governing board. Families USA does not feel that the current language in Section 155.110(c)(3) of the proposed regulation, which limits the number of conflicted parties, inherently means that the board "[r]epresents consumer interests," or is consumer-friendly. We agree with the language in the preamble of the proposed rule that states: "Exchanges are intended to support consumers, including small businesses, and as such, the majority of the voting members of governing boards should be individuals who represent their interests." In accordance with this statement, we recommend that the final rule explicitly state that representatives of consumer interests must be included on the Exchange governing board.

Several publications and state Exchange laws recommend and/or require representatives of consumer interests on the Exchange board. The National Academy of Social Insurance's (NASI) model Exchange legislation, included in their document *Designing an Exchange: A Toolkit for State Policymakers*, states that the governing board must include people who represent the interests of: "[h]ealth care consumers," "[s]mall business owners," and "[o]ther organizations eligible to purchase in the Exchange."[2] The Massachusetts Connector Authority has one spot on its governing board specifically for a "representative of a health consumer organization," one for a "representative of organized labor," and "1 of whom shall represent the interests of small businesses."[3] Maryland's Exchange law reads that three of the nine members of the Exchange governing board must "represent the interests of employers and individual consumers of products offered by the Exchange."[4] Families USA believes that Section 155.110(c) will better allow states to create consumer-friendly Exchanges with the required inclusion of representatives of consumer interests.

We suggest that the final rule include a definition of individuals who may be considered to fill required seats for "representatives of consumer interests." Families USA proposes the following definition: "Individuals who purchase (or, if prior to 2014, will likely be eligible to purchase) coverage through the individual Exchange; small business employees who purchase (or, if prior to 2014, will likely be eligible to purchase) coverage through the SHOP Exchange; and non-profit organizations that have experience representing or advocating on behalf of the individuals in the categories mentioned above."

Families USA strongly recommends that HHS require all Exchange governing boards to prohibit membership for individuals with a conflict of interest. It is contrary to the Exchange's goal to provide affordable health coverage to millions of individuals and small business employees if Exchange boards include parties that have a financial interest in the provision of health insurance and would thus benefit from rising insurance premium costs. There are several state Exchange laws that do not allow conflicted parties to serve on the governing board in any form, such as those enacted in California, Connecticut, Nevada, and Maryland. We recommend that the final rule explicitly defines individuals with a conflict of interest to include individuals or entities affiliated with health insurance issuers that are doing business or seeking business in the area where the Exchange operates, such as insurance agents or brokers, and practicing health care providers or health care facilities. Additionally, this prohibition should explicitly extend to individuals affiliated with trade associations or membership organizations comprised chiefly of the above industries, or with an entity whose primary line of business serves or whose clientele is largely comprised of individuals or organizations identified above as conflicted parties. This would include major vendors, subcontractors, or other financial partners of conflicted parties. Conflict of interest prohibitions should also cover immediate family members or spouses of anyone identified as a conflicted party.

If the final rule does allow for conflicted parties to serve on the governing board, the restriction on the number of conflicted individuals should not only apply to "voting representatives with a conflict of interest," as currently stated in Section 155.110(c)(3), but to all representatives with a conflict of interest. Even if conflicted board members are non-voting members, they can still

influence other members on the board in their voting and decision making and therefore must not comprise a majority of the overall board members.

Families USA supports the areas of expertise that the majority of board members must possess, as listed in section 155.110(c)(4). We believe that this list includes the technical expertise necessary to effectively govern an Exchange. In order to more adequately represent consumer interests, we suggest adding the following areas of expertise to the existing list: "consumer education and outreach," "public coverage programs," and "health disparities."

Recommendations: The final rule should require that the Exchange set advance notice timeframe requirements for public meetings, including advance notice requirements for emergency meetings. It should require that these meetings be announced via public website as well as mass communication in email and non-electronic formats. The final rule should include a standard that all Exchange governing board meetings must be public unless there is a justifiable reason for confidentiality.

The final rule should also explicitly require that multiple representatives of consumer interests serve on every Exchange governing board. It should adopt a specific definition for "representatives of consumer interests." The final rule should also completely prohibit individuals with conflicts of interest from serving on Exchange governing boards. If the final rule does allow for conflicted parties to serve on the governing board, the restriction on the number of conflicted individuals should not only apply to voting representatives with a conflict of interest but to all representatives with a conflict of interest. Finally, the final rule should add "consumer education and outreach," "public coverage programs," and "health disparities," to the list of Exchange board member expertise areas.

<u>d. Governance principles</u>

Families USA strongly supports Section 155.110(d)(1), which calls for an Exchange to "make publicly available a set of guiding principles that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest." This language will provide transparent guidance for the behavior of the governing board while showing the public that the Exchange is an entity whose first priority is the public.

Families USA strongly supports Section 155.110(d)(2), which states: "The Exchange must implement procedures for disclosure of financial interests by members of the Exchange board or governance structure." Disclosure of financial interests will make the board publicly accountable for the decisions it makes and help ensure that it is serving in the best interest of consumers. Since board members may have conflicts with respect to a particular issue or voting matter (but are not inherently conflicted parties as described in Section 155.110(c)), we recommend that in the final rule, conflicted parties are not only required to disclose financial interests but are also required to recuse themselves from voting and leave the premises during discussions regarding issues on which they have a conflict of interest. This will protect the Exchange governing board from making unethical or conflicted decisions that do not support the interests of consumers.

Recommendation: The final rule should require board members with a conflict of interest

regarding a given issue or voting matter to disclose financial interests, recuse themselves from voting, and leave the premises during discussions regarding that issue.

f. HHS Review

Families USA supports the requirement in Section 155.110(f) that HHS can review the "accountability structure and governance principles of a State Exchange." This will help ensure that the Exchange governing and accountability structure is continuing to function as planned over time. We recommend that HHS do an initial review of the accountability and governance structure of state Exchanges as a part of the Exchange approval process prior to the launch of the Exchange. We also recommend that HHS require Exchanges to report any changes in board membership within five business days, and any changes to the Exchange governing structure should receive prior approval from HHS.

Recommendation: HHS should do an initial review of the accountability and governance structure of Exchanges as a part of the Exchange approval process. Any changes in Exchange board composition should be reported to HHS within five business days, and any changes to the Exchange governing structure should receive prior approval from HHS.

§155.120- Non-interference with Federal law and non-discrimination standards

This section requires state Exchanges to follow federal laws and regulations related to their operation and to the Affordable Care Act, but clarifies that state laws that don't interfere with the Affordable Care Act are not preempted. It also prohibits discrimination.

We concur with this section. While the Affordable Care Act sets minimum standards for states with respect to a number of consumer protections, such as health insurance rating practices and essential benefits, the Act clearly allows state law to go further. In addition, the Affordable Care Act does not change state law with respect to a number of other areas that state insurance departments regulate. State Exchanges receive federal establishment grant funds and will process federal premium payments. They must thus adhere to non-discrimination standards under Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, and the Americans with Disabilities Act, and it is in consumers' interests that they do so.

§155.130- Stakeholder consultation

We agree that the eleven groups of "stakeholders" listed in Section 155.130 of the proposed rule provide a diverse array of interests and experience. In particular, we support the inclusion of advocates for "individuals with a mental health or substance abuse disorder" among advocates for enrolling hard to reach populations with which the Exchange should consult. To better represent the variety of challenges that people may face when interacting with the Exchange, we recommend adding individuals with Limited English Proficiency and individuals with disabilities, and their advocates, to the list.

We hope that the Exchange board will naturally consult with this group of stakeholders. However, the final rule should explain how the interaction between the Exchange board and the stakeholders must work. We recommend that the final rule require that the stakeholder group is given the opportunity to regularly offer input to the Exchange governing board. The stakeholder

group should receive advanced notice of Exchange board meetings and hearings, and be given the opportunity to present to the Exchange board at meetings. The Exchange board should seek comment from the listed stakeholders on key issues and decisions and be required to review materials submitted by the stakeholders. The Exchange should also consider surveying the stakeholder group and holding focus groups or discussion meetings with the stakeholders on key issues.

Recommendation: The final rule should add "individuals with Limited English Proficiency and their advocates and individuals with disabilities and their advocates" to the list of stakeholders in Section 155.130. To ensure that the Exchange governing board regularly consults with the stakeholders as required, the final rule should outline the procedures for stakeholders to provide input to the Exchange governing board.

§155.140- Establishment of a regional Exchange or subsidiary Exchange

a. Regional Exchange

We support the statement in the preamble that states should consider how a regional Exchange would meet Exchange requirements and achieve cooperation with each participating state's department of insurance. We recommend that describing how an Exchange will accomplish these tasks, as well as how the regional Exchange will achieve cooperation with each state's Medicaid agencies, be required components of a regional Exchange Plan.

It is critical that a regional Exchange, which would be responsible for determining eligibility for premium credits, Medicaid, and other state health programs, coordinates with the various state agencies that administer Medicaid and other health programs. If a person comes to an Exchange and is found eligible for Medicaid, there would have to be an agreement by each regional Exchange member state to accept the individual's Medicaid enrollment based on the decision of the regional Exchange, or consumers may face gaps in coverage. HHS should ensure that regional Exchanges put such agreements in place and otherwise abide by the requirements for a streamlined, "no wrong door" eligibility and enrollment system.

In addition, regional Exchange plans should have to explain how consumers will be able to resolve complaints or access assistance in a streamlined fashion regardless of which participating state they reside in. A regional Exchange must function as smoothly for consumers as would an Exchange operated by a single state.

We agree with the statement in the preamble that states in a regional Exchange should provide a consistent level of consumer protections across states. Further, we believe it is critical to ensure that consumers do not lose protections that they currently have in their states under a regional Exchange. HHS should encourage states to consider whether potential partner states have comparable levels of consumer protections in their insurance markets, and how they will ensure that residents do not lose any of their current protections, before entering into a regional Exchange. In their regional Exchange plan, states should have to address how they will ensure that consumers will not lose any existing consumer protections under a regional Exchange. Otherwise consumers in a regional Exchange may be exposed to new problems with coverage

from which they were previously protected.

The proposed rule permits regional Exchanges between states that are not contiguous. We believe that the coordination problems posed by regional Exchanges will be exacerbated in regional Exchanges that comprise noncontiguous states and believe that the reasons that such an Exchange would be helpful to consumers are unclear. Therefore, we recommend that any proposals to form regional Exchanges between noncontiguous states only be approved by HHS if there is a compelling justification for why two or more noncontiguous states should share an Exchange. Exchange functions such as ensuring adequate provider networks and contracting with insurance carriers would be difficult in a regional Exchange with noncontiguous states, as health care costs and insurance premiums, provider access, and a number of other relevant factors vary greatly in states across the country.

To ensure that consumers have continuous access to an ACA-compliant Exchange, we recommend that the final rule require a state to give at least 12 months notice that it plans to leave a regional Exchange, analogous to the requirement for if a state decides to turn Exchange operations over to the federal government. This will give the exiting state and the other participating state(s) time to prepare for the change so that consumers do not suffer gaps in coverage or access to a one-stop shop for insurance.

Recommendation: The final rule should require states seeking to establish a regional Exchange to explain in the regional Exchange plan how the regional Exchange will meet all Exchange requirements and coordinate with each state's insurance department and Medicaid agency. States seeking to establish a regional Exchange must agree to accept the regional Exchange's determination of Medicaid eligibility for their residents. Regional Exchange plans must also outline how states will ensure that their residents do not lose any consumer protections and how consumers will receive assistance with problems under a regional Exchange. Noncontiguous states should not be permitted to form regional Exchanges unless they can present a strong justification for why consumers would benefit from such an Exchange. Finally, states should be required to give 12 months notice before exiting a regional Exchange.

b. Subsidiary Exchange

We support the codified statutory requirements that subsidiary Exchanges within a state must serve geographically distinct areas and must serve areas at least as large as a rating area. We would oppose more flexibility in the combination of subsidiary Exchanges allowed to operate in a state, as considered in the preamble. Allowing more than one subsidiary Exchange to operate in the same geographic area would lead to consumer confusion and adverse selection; allowing subsidiary Exchanges that do not at least encompass a full rating area would lead to cherry-picking, as insurers would attempt to avoid areas with sicker or older demographics.

HHS seeks comments on operational or policy concerns about the idea of subsidiary Exchanges that cross state lines. We have the same concerns with such subsidiary Exchanges as we do with regional Exchanges. Namely, improper implementation of a subsidiary Exchange that crosses state lines could result in insufficient coordination between the Exchange and states' insurance

departments and Medicaid programs, confusion for consumers who need assistance with questions or grievances, and diminishing protections for consumers in some states if all existing state laws and regulations were not upheld in an Exchange that crosses state lines.

Recommendation: The final rule should not permit further flexibility regarding the combination of subsidiary Exchanges allowed to operate in a state.

c. Exchange standards

We support the provisions requiring a regional or subsidiary Exchange to meet all of the requirements that an Exchange operating in one full state would have to meet, as well as all of the SHOP requirements. In addition, we support the requirement that the geographic areas served by the SHOP and the individual Exchange must be the same if the Exchanges are operated separately. This will be important for consumers, who may shift between the two Exchanges; for insurers who will want consistency in contracting with the individual and SHOP Exchanges; and for the insurance market, which will likely be more robust and competitive if the SHOP and the individual Exchange serve the same areas.

§155.150- Transition process for existing state health insurance Exchanges

This section presumes that a state Exchange that was in operation prior to 2010 is compliant with federal standards if the state has insured the percentage of its population projected to be covered nationally under the Affordable Care Act, and if HHS has not determined the state to be non-compliant with ACA standards.

We are concerned that this section is written too loosely and could allow a state that does not come close to meeting federal Exchange standards to be presumed compliant. First, this section does not specify which year of national projected insurance rates after ACA implementation states with operational Exchanges must achieve, although the preamble says that the intent is to use 2016 projections. This should be clarified in the regulation itself. In 2014, CBO projects that the national insurance rate for nonelderly people will be 89% including all residents, and 91% excluding unauthorized immigrants; in 2016 and years following, CBO projects that the insurance rate will be 92% including all residents, and the CMS Office of the Actuary and CBO project 94-95% excluding unauthorized immigrants. We recommend the use of CBO's projection for the standard under section 155.150(a)(2). From merged CPS data on statehealthfacts.org, it appears that about nine states could claim to meet the 2014 standard but only two could meet the 2016 standard. Second, the section does not specify what data source will be used to determine if the state's insured population meets the standard. We suggest the use of three-year merged Current Population Survey data unless the state has as accurate or more reliable state survey data available. Third, states should be required to attest that their Exchanges meet the federal Exchange standards before they are presumed to comply. Finally, the language in (a)(2), "The State has insured a percentage…" is confusing since state residents may have private or federal sources of coverage or coverage through state programs. For clarity, this sentence should be revised to read "The insured nonelderly population in the state is not less than…."

Recommendation: The final rule should specify that the percentage insured in a state

seeking presumed Exchange compliance must at least meet 2016 national coverage projections according to CPS data unless a different data source has been found by HHS to be more reliable. It should also require states to attest that their Exchanges meet the federal Exchange standards before they are presumed to do so. Finally, it should clarify subsection (a)(2) to reflect the insurance status of nonelderly state residents.

§155.160- Financial Support for Continued Operations

We support the codification of states' ability to charge assessments on participating issuers, as well as the flexibility to adopt additional mechanisms for generating revenue to fund Exchange operations. We believe that one of the best mechanisms for funding an Exchange is to charge an assessment to not just participating insurers, but to all insurers in the state (which is how many states currently assess premium taxes). While assessments only on participating issuers is one allowable way to obtain funding for continued operations, if a state pursues this model it could result in an unlevel playing field, undermining the viability of the Exchange. Insurers could have a disincentive to participate in the Exchange if the Exchange exposed them to assessments that they would not face in the outside market. Further, insurers would seek to pass such disparate assessments on to Exchange enrollees, resulting in plans with higher premiums inside the Exchange compared to the outside market, which could lead to decreased Exchange participation among consumers. (Since premiums for the same product must be the same inside and outside of the Exchange, this unlevel playing field would likely result in issuers offering different plans in the Exchange compared to their outside market plans.)

Because of these risks, we recommend that the final rule include states charging assessments to all issuers as an example of a preferred Exchange-financing mechanism. Further, the preamble should include a discussion of the risks of pursuing a funding mechanism in which only QHP carriers or participating issuers are assessed, including the resulting disincentive for carriers to participate in the Exchange. The final rule could also list other potential Exchange-financing mechanisms, such as assessments on third party administrators (TPAs) and reinsurance carriers, as examples. States should be required to include in their Exchange approval plans to HHS their plans to mitigate any risks for adverse selection that could result from the Exchange-financing mechanism that they elect to use.

One of our greatest concerns about Exchange financing is how consumers would be affected by carrier assessments. The statute states that premiums for the same product must be the same regardless of whether the product is sold inside or outside of the Exchange. In accordance with this requirement, we recommend that the final rule clarify that if an Exchange seeks to assess only QHP insurers, assessments cannot be passed on to Exchange plan enrollees only, thereby increasing their premiums compared to the premiums for the same product in the outside market. Further, plans and Exchanges should be prohibited from charging an Exchange enrollment fee or otherwise passing on the cost of an assessment to Exchange enrollees outside of the premium price. We believe that such a fee would violate statutory requirements that consumers not pay more for the same coverage inside the Exchange than they would in the outside market. Even if a plan is offered only inside of the Exchange, a consumer enrollment fee for Exchange coverage would create a disincentive for consumers to purchase coverage through the Exchange, as

coverage may be available to them in the outside market without any enrollment fees. Therefore, such enrollment fees for Exchange coverage should be uniformly prohibited in the final rule.

The preamble solicits comments on whether the final rule should limit when and how user fees are collected, including whether they should be assessed annually. We are concerned that, particularly in the early years of Exchange operations, limits on how and when Exchanges may assess carriers could jeopardize the ability of Exchanges to maintain adequate operational funding. Therefore, although we agree that carriers should receive advance notice of assessments, restrictions on an Exchange's ability to assess carriers how and when it sees fit should not be added to the final rule.

Recommendation: The final rule should include assessments on all issuers, as well as assessments on TPAs and reinsurers, as examples of Exchange-funding mechanisms. The final rule must clarify that carriers and Exchanges may not pass assessments on to Exchange enrollees only due to ACA requirements that premiums for the same product must be the same inside and outside of the Exchange. The rule must also state that Exchange enrollment fees for consumers on top of premiums are uniformly prohibited. The final rule should not place any additional restrictions on how and when Exchanges may assess carriers.

§155.200- Functions of an Exchange

We support ensuring that all Exchanges perform a minimum set of functions. It is particularly important to consumers that the proposed rule requires Exchanges to perform eligibility determinations across a variety of programs, including the premium tax credits and cost-sharing reductions available through Exchanges, Medicaid, and the Children's Health Insurance Program. It is appropriate, and consistent with the law, to put Exchanges at the center of a streamlined, coordinated eligibility process. We support the preamble's statement that the eligibility and enrollment function of the Exchanges should be consumer-oriented and should minimize administrative hurdles and unnecessary paperwork for applicants.

Not only must an Exchange be capable of carrying out the required functions, it must perform these functions well and ensure that consumers receive the protections and benefits required by the ACA. The Exchange Plan approval process provides one mechanism to ensure a state Exchange performs these functions adequately. We further recommend that HHS establish objective ways to measure whether Exchanges are successfully carrying out their required functions on an ongoing basis. For example, to ensure that Exchanges are properly carrying out their eligibility and enrollment functions, HHS should review data such as the percentage of a state's population that has health insurance and the percentage of consumers coming to an Exchange that successfully complete the enrollment process, whether in the Exchange, Medicaid, or other state health programs. Another important element to review is the change in Exchange premium costs over time, possibly in relation to the individual and small-group markets outside of the Exchange. HHS could also monitor consumer satisfaction with Exchanges as a benchmark of whether the entities are serving their populations appropriately.

The requirement for an Exchange to report data necessary for evaluation should be added to the Exchange approval standards, and HHS should propose specific measures of Exchange success.

Once Exchanges are up and running, HHS should formulate specific standards on various data points that the Exchanges must meet. The requirement to supply data to help monitor Exchange performance should be placed on state Exchanges as well as federally facilitated Exchanges, and the data should be publicly available.

Function (d), establishment of an appeals process for individual eligibility determinations, like function (f), quality activities, is a critical function of the Exchange that, according to the preamble, will be a subject of future rulemaking. It is important that future rules for function (d) clarify that consumers have all of the rights to due process that they have now in the Medicaid fair hearing system, since Exchange appeals may determine both Medicaid and premium credit eligibility. When appeals are taken, they must be decided by an impartial hearing officer. Further, the appeal system must be binding on the Medicaid agency when a Medicaid matter is determined; provide for appeals when applications are not acted upon promptly as well as when there are denials or disputes about the correct amount of premium payments; ensure that when a dispute involves whether someone should be in Medicaid rather than premium credits or vice versa, the consumer is assured one of these forms of coverage until the dispute is settled and held harmless for any overpayments that result to the consumer; provide for continuation of benefits during an appeal; provide for in-person hearings; and be completed within federally established time standards.

The proposed rule does not address what will happen if an approved state Exchange fails to perform its required functions. A process must be established to promptly provide relief to consumers in this instance. Besides a process to decertify a state Exchange or to provide for sanctions, a system should be in place to immediately allow consumers to apply to the federal government for advance premium credits if the state Exchange is not processing applications in a timely manner and for consumers to be determined eligible for Medicaid if appropriate.

Recommendation: The final rule should establish measures to evaluate how well Exchanges are functioning and establish a system to collect data relevant to these measures that is made publically available. The final rule must also further clarify the appeals system for eligibility determinations and provide remedies for consumers if a state Exchange fails to perform its functions, and especially if a state Exchange fails to process applications for premium credits and Medicaid on a timely basis. As Exchanges become more established, the federal government should set specific benchmarks that Exchanges must meet.

§155.205- Required consumer assistance tools and programs of an Exchange

a. Call center

We support the statutory requirement that Exchanges must operate toll-free call centers, but believe additional details and standards are needed in the final rule as to how they must function. We strongly support the proposal in the preamble that such call centers must operate both within and beyond normal business hours. Many people who will be using the Exchange are working during the day and will need to be able to contact the Exchange when they are not at work.

In order to ensure that people receive meaningful assistance from Exchange call centers, they

should be required to adhere to performance standards that limit hold times, ensure that few callers hang up before receiving answers to their questions, and ensure that the centers provide correct and useful information. Call centers should also be required to provide effective oral communication for all LEP individuals. The importance of establishing standards for call centers is illustrated by experience with the Medicare 800 call center, which has worked to improve its services and provide additional training to call center staff in recent years, partly in response to concerns that surfaced when the Office of the Inspector General and the General Accounting Office surveyed Medicare beneficiaries' satisfaction with the center.

Further, many states are used to establishing call center standards and measuring performance. For example, we understand that the Michigan Health Insurance Consumer Assistance Program's call center ensures that all callers receive live assistance and that calls are answered and routed with no more than a three-minute hold time. Three-quarters of callers are helped during their first call, and the remaining callers receive follow-up calls within one business day. Callers are also able to leave a voicemail message after business hours providing contact information and times when they are available during business hours. Callers who leave voicemail messages receive a response within one business day as well.

The preamble notes a number of areas on which call centers should provide assistance, including the types of QHPs offered; premiums, benefits, cost-sharing and quality ratings of QHPs; categories of assistance available; and the application process. These areas should be named in the regulation. Call centers should have access to Exchange databases so that they can determine the status of a caller's application, enrollment, or receipt of benefits and provide appropriate services to resolve a problem.

Call centers should maintain some demographic data about callers and should maintain data about the types of problems that callers face and how they are resolved. This will help the Exchange improve its services.

b. Internet website

We strongly support the statutory requirement that Exchanges operate an internet website where individuals can compare available QHPs using the measures stated in the proposed rules. We strongly agree that presenting "standardized comparative information on each available QHP" will allow consumers to more easily compare plan information. We therefore recommend that HHS require QHPs to submit plan information for posting on the Exchange Website, including the Summary of Benefits and Coverage (SBC) and Uniform Glossary of Medical and Insurance Terms (Glossary) required in section 2715 of the ACA, in a uniform format that is compatible with the search function of the of the Exchange website, allows side-by-side comparison of plans, and is accessible for a broad range of computer operating systems, platforms, and Internet broadband speeds. Consumers should not be required to leave the Exchange website or download additional software in order to view documents such as a plan SBC or the Glossary. Additionally, consumers should be able to view these documents without creating a password-protected account, though, as described below, we believe that password-protected accounts on the website can be helpful for consumers in some instances. However, requiring these extra steps to access QHP information would create unnecessary confusion and barriers to obtaining information,

especially for consumers with low computer literacy. The Exchange website should also notify consumers that they can request paper or electronic copies of the SBC and Glossary from the insurance issuer and provide information on how to contact the issuer by telephone, email, fax, mail and online. Consumers should be able to specify how they prefer to receive these documents, with a paper option always available.

It is also essential that applicants and enrollees can access up-to-date provider directories online as well. Online provider directories should have a search capacity and allow consumers to identify providers that are accepting new patients and providers that offer health care services in languages other than English. The responsibilities of plans and Exchanges to keep these directories updated should be clearly delineated, as we describe in our comments on Section 156.230.

We also fully support the proposed requirements that the website be accessible to people with disabilities and people with LEP. The Exchange's website must be user-friendly and accessible to all consumers, including those with low literacy, those with limited knowledge of basic health care and insurance coverage concepts, and those unfamiliar with computers and the Internet. To provide access to Exchange website information for people with disabilities, Exchange websites must be section 508 compliant and compatible with assistive products, including refreshable Braille displays and screen readers that translate the content of a computer screen into automated audible output.

For LEP individuals, key information should be translated into languages spoken by 500 or five percent of Exchange service area residents, whichever is less, and taglines should explain how to access information that is not translated and how speakers of other languages can obtain language assistance. This information should direct consumers to call the Exchange to access oral communication of the information on the website in their primary language or translated Exchange documents free of charge. The Exchange website should also link to translated documents directly. Further, HHS must ensure that information is translated according to recognized standards by qualified and competent translators and not by "machine" translation, and that this information is accurate. "Machine translation" refers to the use of a computer program to automatically translate information from one language to another. Currently, neither free nor commercials machine translation programs provide sufficiently accurate translations to rely upon for use with LEP individuals. Instead, best practices that are recognized by the American Translators Association (ATA) must be used. ATA offers a guide called "Getting It Right" (available at https://atanet.org/docs/Getting_it_right.pdf) that offers advice on what to look for when evaluating translation services. The Exchange must also offer timely and adequate oral assistance through competent interpreters or bilingual staff to all LEP individuals requesting assistance. This will ensure that the Exchange is compliant with Title IV of the Civil Rights Act and the nondiscrimination provision in Section 1557 of the ACA. Finally, it is critical that all information provided on the Exchange website and in translated documents be written in plain language that is clear, consistent, and concise, and at the lowest reasonable education level so that all consumers, including those with low literacy and numeracy levels, can understand the information. Exchanges should focus-test all materials, including translations, with a diverse group of consumers to ensure that these standards are met.

We further support requirements that the website provide information on the cost of coverage in the Exchange, including information on premiums, premium tax credits, cost-sharing, cost-sharing assistance, and exemptions from the individual mandate penalty. We also support requirements that the website provide information on Navigators and other consumer assistance programs, including regularly updated contact information. We fully support the requirement under the ACA and in the rule that the website must allow for an eligibility determination and enrollment in coverage. Due to the complexity and volume of information that is to be provided through the Exchange website, it will be important to provide people with assistance in understanding this information. HHS should require that information regarding how to apply for coverage and how to obtain assistance applying for and understanding coverage options be front and center on all Exchange websites. The phone number for the call center should be prominently displayed and we also suggest that HHS consider whether Exchanges should be required to make online "live chat" assistance available for consumers attempting to apply and enroll online. If live chat assistance is provided, it should follow the same principles listed above for call centers.

Exchange websites should allow users to create a secure account where they can store, access, and update personal information. This has become the standard for online service providers, and should allow individuals to check their eligibility, coverage, and premium payment status and update their account upon a change in circumstances (such as a change in income or household composition). Having secure user accounts will also allow third party consumer assistance programs to provide more accurate assistance, since with the consumer's permission they will be able to view the consumer's coverage history, application status, and coverage options.

c. Exchange calculator

We support inclusion of a calculator to allow consumers to view the cost of premiums and compare QHPs after premium tax credits and cost-sharing assistance have been applied. The calculator should be simple to use, easy to understand, and should not require users to perform any calculations on their own. The calculator should auto-populate the amount of credit and cost-sharing assistance the user is eligible to receive, and the user should also be able to manipulate the settings to simulate the cost of coverage after a change in circumstances. The page on which the calculator is located should also describe the importance of reporting changes in income; provide information about how premium credits, cost-sharing assistance, and out-of-pocket maximums are determined based on income; and provide clear links to information about available silver-level plans.

d. Consumer assistance

We support the requirement that the Exchange have a consumer assistance function that includes the Navigator program and that it refers consumers to other consumer assistance programs when available and appropriate. Exchanges should ensure that in-person consumer assistance is available to people who do not have telephones or internet access. On the Exchange's website, we recommend that consumers be able to view sources of consumer assistance by languages spoken and areas of expertise (eligibility, plan selection, appeals, etc.). Although some states will have received grants for consumer assistance programs under Section 2793 of the ACA to assist consumers with issues ranging from appeals of health plan decisions to appeals of premium credits, not all states have programs that are funded or adequately funded to carry out this work.

Thus, while Exchanges should refer to these programs when appropriate, Exchanges must directly provide this assistance to Exchange consumers when there is not another program with the capacity to do so. The preamble asks for comments on possible duplication of services. We believe that duplication is unlikely – consumers generally use assistance appropriately and programs naturally establish referral arrangements among themselves to avoid duplication. We are much more concerned about whether there will be adequate resources to assist consumers when problems or questions arise, and believe that should be the focus of the final rule.

e. Outreach and education

Consistent with the preamble, the rule should require that outreach and education be conducted broadly and in ways accessible for people with disabilities, LEP, and low literacy, as well as to other hard to reach populations that experience health disparities, including those with mental illness and substance use disorders.

Recommendation: The final rule should include additional standards regarding the operation of call centers; provide information and assistance helpful to people with disabilities and LEP and consider other ways of enhancing online tools; provide in-person assistance as needed; and require that the Exchange itself provide assistance with appeals and other complex problems when assistance is not available through referral arrangements with ombudsman or other consumer assistance programs.

§155.210- Navigator program standards

We consider a robust, impartial Navigator program to be a critical component of Exchange outreach and enrollment. Therefore, we believe that the rule must ensure that Exchanges award Navigator grants to the entities that can best serve likely Exchange customers in their communities, without any conflicting interests and with requirements for appropriate training and/or certification. We support the rule's requirement that each Exchange's Navigators represent more than one type of eligible entity, and offer the following specific comments to strengthen section 155.210.

a. General Requirements

The rule generally requires Exchanges to award grant funds to eligible entities to serve as Navigators. However, the rule does not specify a required scope or capacity for each Exchange's Navigator program, despite the ACA's requirement that Navigator programs fulfill a number of duties for potential Exchange enrollees. We are concerned that some Exchanges may therefore implement very small Navigator programs that only have the capacity to serve a narrow share of Exchange-eligible consumers or businesses. We recommend that HHS consider whether more specific and measurable Navigator program standards would help address this problem, such as standards requiring the Navigator program to serve clients within a specific amount of time, or standards requiring that the Navigator program demonstrate that the combination of grantees are conducting outreach activities targeted to each income group, linguistic group, geographical area, and segment of the small business community with high rates of uninsurance.

Recommendation: HHS should consider additional requirements to ensure that Navigator

programs have sufficient capacity to serve all individuals and small businesses in need of assistance.

b. Entities eligible to be a Navigator

The rule mirrors the statutory requirement that entities seeking a Navigator grant demonstrate to the Exchange that they have, or could readily establish, relationships with likely Exchange customers. However, the rule does not provide clarification for how applicants for the Navigator program must demonstrate that capability. We recommend that HHS include requirements, or at the very least examples, for how Exchanges can comply with this provision to assess the capability of Navigator applicants to reach targeted populations. For example, Exchanges could be required to solicit action plans from applicants for the Navigator program that would outline who the potential Navigators intend to assist (including estimates for how many people or businesses they intend to serve) and how they will reach those clients.

Further, we understand that, as described in the preamble, an entity need not be able to reach all relevant groups (employers and employees, consumers, including uninsured and underinsured consumers, or self-employed individuals) in order to be a Navigator. However, we recommend that the rule clarifies that each Exchange's overall Navigator program must have the capacity to serve all of those groups. Additionally, the final rule should require Exchanges to ensure that segments of the population with high concentration of need have access to Navigators. For example, if an Exchange only awards grants to entities that are skilled in reaching small businesses, those seeking individual coverage may not have access to Navigator services. Exchanges should be required to analyze data for their service area to identify individuals and small businesses that will likely be eligible for Exchange coverage and use this information to focus Navigator funding to reach segments of the population that have the greatest need for assistance. Analysis of the Exchange service area should look for geographic concentrations of eligible enrollees as well as other characteristics of the likely eligible population including race/ethnicity, language, age, income, and other relevant factors.

The preamble solicits comments on whether additional requirements should be placed on Exchanges to make sure that Navigators do not have conflicts of interest. In addition to our strong recommendation for prohibiting Navigators from serving as health insurance producers in any market (as described further in our comments on section 155.210(c)), we recommend that the rule specify that Navigators not be health insurance issuers, employees of health insurance issuers, or active health insurance brokers. Navigator entities must be required to sign contracts agreeing to avoid any activity that could be considered a conflict of interest. Exchanges should monitor referral and enrollment patterns of all Navigators to ensure that conflicts of interest are not influencing Navigator activity.

We strongly support the provision in 155.210(b)(2) that requires an Exchange to include at least two different types of eligible entities in its Navigator program. This provision is critical to ensuring that Navigator programs meet the needs of diverse populations, instead of being comprised of just one type of entity that may reach only a narrow segment of the Exchange-eligible population. For example, this provision prohibits an Exchange from selecting only brokers or agents to be Navigators—a practice that would likely result in inadequate assistance

for many consumers, such as those who do not speak English as their first language, those who reside in areas that are infrequently served by brokers, and those who teeter between Medicaid and premium credit eligibility. These groups may be better served by community or consumer-focused non-profits.

Because we believe that the involvement of community and consumer-focused non-profits in the Navigator program is critical to reaching consumers (and particularly those who are uninsured or underinsured), we strongly support and urge HHS to adopt the proposal under consideration in the preamble to require that at least one of the types of entities serving as Navigators in each Exchange be a community or consumer-focused non-profit organization. We believe this proposal would best ensure that those most in need of assistance are served by the Navigator program.

Additionally, as mentioned earlier, we believe that Exchanges should be required to analyze data for their service area to identify individuals and small businesses that will be likely eligible and use this information to focus Navigator funding to reach segments of the population that have the greatest number of individuals likely to enroll in QHPs and the greatest need for assistance.

Section 155.210(b)(2) also provides examples of "other entities" beyond those specifically listed in the statute that may serve as Navigators. These include public entities like "State or local human service agencies." Because those entities are branches of government, HHS must ensure that their service as Navigators is not undermined by conflicting interests, such as a disincentive to enroll individuals into public coverage due to concerns about government funding or political climate. Therefore, it is critical that the standards that apply to all Navigators be strictly enforced when a Navigator is a public entity.

Under Section 155.210(b)(1)(ii), the rule defers the licensing, certification, or other standards that Navigators must meet to the states or the Exchanges. We believe that Navigators should be appropriately trained to ensure that they have a thorough understanding of the health coverage issues on which they will be providing assistance and that they comply with strong ethical standards. However, we are concerned that allowing each state or Exchange to determine Navigator licensing, certification, or other standards could lead to some programs requiring inappropriate licensure of Navigators, such as producer licenses for all Navigators. We believe that requiring all Navigators to obtain a producer license would violate the intent of the program, which is to provide assistance to a wide variety of Exchange-eligible consumers and businesses through diverse entities that meet the needs of various populations. It would also undermine the requirement of section 155.210(b)(2) that each Exchange must include at least two different types of eligible entities in its Navigator program. A requirement to obtain a producer license could greatly hinder the ability of many entities that are eligible for the Navigator program under the ACA, such as community and consumer-focused nonprofits, commercial fishing industry organizations, ranching and farming organizations, and unions, to participate in the program.

Further, the required training and testing for receiving a producer license may not be relevant or appropriate for preparing an individual to perform the duties of a Navigator. For example, to become an insurance broker, there are often pre-licensing requirements for training on insurance

topics and ethics (for example, 20 hours of such training in one state; 40 hours for each line of insurance in another), an exam, and continuing education requirements (for example, 24 hours every two years).[5] In some states, the broker licensure exam requires knowledge of many types of insurance, not just health coverage.[6] There are also licensure fees that may be nominal or may be a few hundred dollars, and sometimes fingerprinting is required.[7]

The trainings and testing that individuals must undergo to become brokers contain a great deal of information that is unnecessary for a Navigator to know, but exclude pertinent information that is critical for being a Navigator. For example, brokers are not generally trained on public coverage programs such as Medicaid, the Children's Health Insurance Program (CHIP), or state coverage programs. Therefore, in order to meet the goal expressed in the preamble to implement "appropriate" Navigator licensing, certification, or other standards, the final rule must state that Exchanges or states may not require eligible entities to obtain a producer license in order to become a Navigator.

Instead of using producer licensing criteria, Navigator certification should require thorough knowledge of eligibility and enrollment policies in public programs, local consumer assistance programs, eligibility and enrollment for the ACA's premium tax credits and cost-sharing subsidies (including issues such as the importance of reporting changes in income), safeguarding consumer information, and how to assist consumers in choosing plans that best meet their needs. Further, Navigators should comply with privacy laws and fair information practices governing the Exchanges as part of any contractual agreement between the Exchanges and Navigators, regardless of whether Navigators are licensed. (For example, Navigators should ensure they are collecting only the minimum personal information necessary to fulfill their duties, that they use the information only for the specific, allowable purposes, and that consumers utilizing Navigators are informed about the collection and use of such information.)

The system for certifying Navigators should not resemble a broker-licensing process, but should instead be akin to the processes used in many states to train State Health Insurance Assistance Program (SHIP) counselors who help Medicare beneficiaries understand and enroll in Medicare benefits.[8] In addition, some states, like California, have training programs for Medicaid "Certified Application Assistants" that could also serve as models for Navigator training and certification programs.[9] The intended role of a Navigator resembles that of a Medicare SHIP counselor and Medicaid Certified Application Assistant, so these programs—not broker-licensing policies—should serve as the foundation for Navigator licensure, certification, or other standards. We recommend that HHS include these programs as examples of appropriate Navigator certification models in the preamble, while clarifying that broker licensure is not appropriate for Navigators.

Further, we recommend that HHS develop an online training and certification program for Navigators that Exchanges may adapt to their needs. This will save states from duplicative efforts and will ensure that Navigators receive uniform information about federal requirements relative to their duties. Training should explain, for example, the basics of premium credits and the importance of updating income information if there have been significant changes since the previous tax year; how the Exchange will screen and enroll eligible people in Medicaid and

CHIP; how to compare plans and use standard plan documents; the basics of individual and employer responsibility; how Navigators may facilitate enrollment; requirements to provide fair and unbiased information; the prohibitions on Navigator conduct, including activities that would constitute a conflict of interest; and where to refer consumers for further information and help.

Recommendation: The final rule should specify the process through which Exchanges must assess whether potential Navigators have or can form relationships with Exchange-eligible consumers and businesses and should clarify that each Navigator program must have the capacity to serve all types of potential Exchange customers. The final rule should also expand the conflict of interest requirements for Navigators. It should maintain the requirement that each Exchange have Navigators representing at least two different eligible entities and must specify that at least one of those entities must be a community or consumer-focused nonprofit organization. The final rule must state that Exchanges or states cannot require all Navigators to obtain producer licenses, and should provide examples of appropriate Navigator certification models, such as the certification processes for SHIP counselors or Medicaid Certified Application Assistants. We strongly recommend that HHS develop a model training and certification program for Navigators that Exchanges can adapt to include state-specific information.

c. Prohibition on Navigator conduct

The rule reiterates the statutory prohibition on health insurance issuers serving as Navigators, as well as the prohibition on Navigators receiving any consideration directly or indirectly from any issuer in connection with the enrollment of individuals or employers in a QHP. We strongly support these provisions. The preamble further describes consideration as including "any monetary or non-monetary commission, kick-back, salary, hourly wage or payment." We recommend also specifically adding "grants" to that list.

Although we support the ACA provision reflected in §155.210 (c), we strongly oppose the rule's interpretation of this provision, as stated in the preamble, to allow Navigators to receive "compensation from health insurance issuers in connection with enrolling individuals, small employers or large employers in non-QHPs" while also serving in their Navigator role. We believe that there is no way that a Navigator could comply with the statutory requirement to "provide information and services in a fair, accurate, and impartial manner," as reiterated in §155.210 (d), and also broker health insurance to individuals and employers outside of the Exchange. The preamble to section 155.210 (c) requests comments on "whether there are ways to manage any potential conflict of interest that might arise" from a Navigator simultaneously serving as a health insurance broker outside of the Exchange. We believe that regardless of the type of training that a Navigator receives, if Navigators are selling health plans outside of the Exchange, the advice that they provide to consumers inside the Exchange may be influenced by their role as a broker. For example, if a Navigator sells a certain carrier's products outside of the Exchange, the Navigator may be motivated to drive consumers inside the Exchange to that same carrier's products, regardless of whether those products are the best option for the consumer; if the Navigator receives higher compensation for enrollments from a carrier outside of the Exchange, they may be motivated to drive consumers outside of the Exchange to purchase a product. This would clearly violate the ACA requirement that Navigators provide fair and

impartial information. Further, accountability for grant funding would be difficult in this scenario– a Navigator/producer might claim payment under a Navigator grant for counseling a client even though the client ultimately enrolled outside of the Exchange where the Navigator/producer was again paid for the enrollment. Therefore, the final rule must state that, in order to comply with the ACA, Navigators may not be active health insurance producers in any market and may not receive direct or indirect consideration from any health insurance issuer. We see this as the most important way that the conflict of interest provisions described in §155.210 (b)(1)(iv) and the requirements of §155.210 (c) must be improved. If the final rule does not prohibit producers in any market from being Navigators (as we strongly recommend), it should at least state that brokers or agents who sell coverage in the outside market and also want to be Navigators must not receive commissions outside the Exchange higher than what they receive on a per person basis from their Navigator grant.

Recommendation: The final rule must state that Navigators may not serve as active health insurance producers in any health insurance market and may not receive consideration from any health insurance issuers, inside or outside of the Exchange, during their Navigator term. The rule should also expand the list of prohibited considerations from insurers during the Navigator term to include grants.

d. Duties of a Navigator

The preamble for §155.210(d) states that Exchanges must ensure that Navigators perform their duties as required, and that Exchanges may require additional standards for their Navigator programs beyond those in the ACA and corresponding rules. We support these provisions. We believe the best way to ensure that Exchanges perform sufficient oversight over their Navigator programs is to specify a defined role for HHS in monitoring Exchanges to make sure that Exchanges verify that all Navigators comply with the standards outlined in the ACA and corresponding rules. We recommend that HHS expand section 155.210(d) to clarify how federal oversight of Exchange Navigator programs will occur. Such federal oversight should verify that Exchange Navigator programs meet the capacity to fulfill Navigator duties for all potential Exchange enrollees in need of assistance within a reasonable amount of time.

Section 155.210(d)(1) states that it is a duty of a Navigator to maintain expertise in "eligibility, enrollment, and program specifications." We recommend that the rules specify that this requirement includes expertise regarding Medicaid, CHIP, and Basic Health or other state-funded coverage programs for which Navigator clients may be eligible. Since individuals experience frequent income volatility and people will transition between eligibility for different coverage programs, it is critical that Navigators have a comprehensive understanding of all coverage options (private or public) in an Exchange's service area. Without such comprehensive knowledge, Navigators will be unable to direct consumers to the best coverage option for them. Further, we recommend that the final rule be more specific regarding the duty of Navigators to inform potential Exchange enrollees about premium tax credits and cost-sharing assistance for QHPs. Section 1311(i)(3) of the ACA requires that Navigators "distribute fair and impartial information concerning enrollment in qualified health plans, *and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost sharing reductions under section 1402*" [emphasis added]. It is estimated that 81 percent of individuals purchasing

their own coverage through the Exchanges in 2019 will receive subsidies.[10] Navigators can play a major role in helping these consumers understand how to apply for these subsidies.

Section 155.210(d)(2) states that Navigators must "provide information and services in a fair, accurate, and impartial manner." As we recommended earlier, the regulations must clarify that in order to meet this standard, a Navigator may not be an active producer in any health insurance market, inside or outside of the Exchange. Overall, we believe that the best way to ensure that Navigators provide information and services in a fair, accurate, and impartial manner is to prevent any entities with conflicts of interest from participating in the program.

Additionally, to help ensure that Navigators provide information in a fair, accurate, and impartial manner, and to prevent fraud and abuse, Navigators should be required to ensure that all staff performing Navigator duties are appropriately certified, maintain certification and are capable of carrying out their duties. Staff must be provided with initial training and their work should be monitored on an ongoing basis. The preamble states that standards related to the content of information shared, referral strategies, and training requirements to be included in grant award conditions are under consideration. We support the adoption of those standards, and would recommend the training processes used in Medicare SHIP programs and in some states' Medicaid Certified Application Assistant programs as models for the development of a Navigator training program.

Furthermore, Navigator entities must not have a conflict of interest as specified in §155.210(b)(1)(iv) and they must also ensure that each staff person is also free of any conflict of interest. When hiring staff, Navigator entities must ask potential employees to disclose all direct conflicts of interest. Direct conflict could include being employed by and/or holding other financial interest in conflicted entities, such as health insurance issuers and producers, which could stand to gain financially by the actions of the staff person. People with direct conflicts of interest must not be hired to perform Navigator duties. Staff should also be required to disclose indirect conflicts of interest such as having a spouse that is employed by an entity that could stand to gain financially by the actions of the staff member performing Navigator duties. On an annual basis, staff should be trained on fraud, abuse, and conflicts of interest and be asked to complete a conflict of interest disclosure form. Applications for Navigator funding should require entities to provide a work plan that includes staff training, staff decision support, and other strategies to address any potential conflicts or appearance of conflicts of interest among staff. Any staff with newly emerging direct conflicts of interest should either end the conflict of interest or end their employment with the Navigator entity, and any staff with newly emerging indirect conflicts of interest should be required to disclose such conflicts and be monitored closely to ensure that they are appropriately acting in the best interest of consumers.

We further recommend that HHS develop a national reporting system in the event that an individual or entity serving as a Navigator is found to be committing fraud or is barred from an Exchange for deceptive activities. We hope that Exchanges will oversee their Navigator programs carefully enough that this problem will not arise, but in the event that unscrupulous individuals become Navigators, a national reporting system will prevent them from repeating their practices in other states and Exchanges.

Section155.210(d)(5) requires Navigators to provide information in a manner that is appropriate to culturally and linguistically diverse individuals and to individuals with disabilities. To ensure that individuals with limited-English proficiency can obtain adequate assistance, Navigator programs should have printed outreach materials available in certain languages based on the service area. Navigator programs must have oral linguistic capacity, including bilingual staff and targeted outreach, in many more languages. Navigators should designate entities to provide language-specific outreach. Additionally, each Navigator entity must be able to assist callers in other languages through a language line.

We support the requirement that Navigators provide information in a manner that is culturally and linguistically appropriate. The final rule should specify that Navigators should be held to the same standard as the Exchange and thus must comply with both Title VI of the Civil Rights Act and section 1557 of the ACA. Navigators should ensure that written materials are translated in all languages where the lesser of 5 percent of the population or 500 LEP individuals in a service area speak a language. If there are fewer than 50 persons in a language group that reaches the 5 percent trigger, the Navigator does not translate vital written materials but instead provides written notice in the primary language of the LEP language group of the right to receive competent oral interpretation of those written materials free of charge. The standard for oral language assistance requires the Navigators to provide adequate and timely language services to everyone requesting assistance. This could include using a language line.

Recommendation: A description of a federal oversight process for Exchange Navigator programs should be added to section §155.210. The rule should specify that duties of a Navigator include providing accurate information on public and private coverage programs and premium and cost-sharing assistance for QHPs. The requirements that Navigators provide information and services in a "fair, accurate, and impartial manner" should be described with greater specificity and should state that Navigators may not be active health insurance producers inside or outside of the Exchange, and that Navigator staff must be trained appropriately and not have conflicts of interest. The final rule should specify that Navigators must meet the same standard as the Exchange regarding the provision of culturally and linguistically appropriate information, including complying with both Title VI of the Civil Rights Act and section 1557 of the Act.

e. Funding for Navigator grants

We understand that, as described in 155.210 (e), the ACA prohibits federal funding for Navigator programs. Therefore, Exchanges will have to develop their own financing mechanisms for the Navigator program. We believe it is important that HHS monitors Navigator programs to ensure that they have sufficient funding to meet the needs of all potential Exchange enrollees. We support the provision of the preamble stating that Exchanges may seek federal Medicaid and/or CHIP funding when Navigators perform Medicaid or CHIP administrative functions.

Recommendation: The final rule should specify that HHS will monitor Navigator programs to ensure that they have sufficient funding to meet the needs of all potential Exchange enrollees.

Finally, we strongly support the proposal under consideration in the preamble of Section 155.210 to require that Exchanges have Navigator programs operational no later than the first day of the initial open enrollment period. Consumers will have a limited amount of time to learn about the Exchange and their coverage options, so the help of Navigators during the entirety of the enrollment period is essential to getting people enrolled in appropriate coverage.

Recommendation: The final rule must require Exchanges to have Navigator programs fully operational by the first day of the initial Exchange open enrollment period.

§155.220- Ability of states to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs

The statute permits states to allow agents and brokers to assist in Exchange enrollment. States are currently exploring many issues related to producer involvement.

a. General rule

While different states may come to different conclusions about producers' roles and reimbursement in the Exchange, there should be widespread agreement in certain areas and it would be helpful to have these elements discussed in the preamble and included in the regulation. At a minimum, Exchanges should be required to develop rules to protect against producers steering enrollees to particular plans for financial or other reasons unrelated to the consumers' best interests and should monitor compliance with these rules. If particular agents or brokers are found to be steering enrollees or violating other rules, they should be prohibited from engaging in enrollment. If states are not required to institute these practices, brokers may have incentives to steer healthier individuals, employers, and employees to particular plans inside or outside the Exchange, leading to adverse selection against the Exchange or among plans within an Exchange. In addition, the final rule should make clear that an Exchange cannot require enrollees to use the services of an agent or broker to obtain QHP coverage.

Recommendation: The final rule should indicate that states where agents and brokers may enroll individuals in the Exchange must develop rules and a monitoring system to prevent adverse selection due to producer steering of enrollees. It should also clarify that applicants for Exchange or SHOP coverage cannot be required to use the services of an agent or broker in order to enroll in a QHP.

b. Website disclosure

Section 155.220(b) indicates that Exchanges may provide information about agents and brokers on their websites. We recommend a requirement that this information, when provided, be displayed alongside information on Navigators, call centers, self-enrollment, or other available options for enrollment in the Exchange. Further, any agents or brokers that are prohibited from enrolling in the Exchange (as described in our comments on section 155.220(a)) should be listed on the website as well. While it should be optional for an Exchange or SHOP to display information regarding licensed agents and brokers on its website, it should be required that Exchanges and SHOPs transparently display any broker fees for Exchange coverage online.

We note that the preamble states that Exchanges may wish to contract with some web-based entities with experience in health plan enrollment. Any such contracts must not produce confusion for individuals and small businesses but should instead make enrollment easier and make coverage options clearer for consumers. We strongly support the preamble's statement that Exchanges remain responsible for ensuring that the statutory and regulatory requirements pertinent to the relevant contracted functions are met, congruent with section 155.110 of the proposed rule. We also support the statement that premium-tax credits can only be obtained from the Exchange itself.

Recommendation: The final rule should clarify that information on all avenues for QHP enrollment must be posted on the same page if producer information is posted on an

Exchange website, and information on producers that have been disciplined or prohibited from selling Exchange coverage should also be listed. Further, Exchanges must be required to display information about broker fees on their websites.

§155.230- General standards for Exchange notices

We agree with the proposed requirements for Exchange notices, as clear notices to consumers and an annual revaluation of the notices will be critical to helping people understand their coverage. However, we request that the final rule clarifies the LEP standards. Notices should be translated when 5 percent or 500 LEP individuals, whichever is less, are included in an Exchange or QHP's service area. These are language thresholds that HHS and DOJ use in other programs, such as for marketing of Medicare Part D plans. All Exchange and QHP notices should also include translated taglines in 15 languages that provide information on how to access translated materials and oral language assistance. Exchanges must ensure that translation is done according to recognized standards by qualified and competent translators and not by "machine" translation, as described in our comments on section 155.205.

Section (a) refers to notices that are "sent." In addition to mailed notices, some notices may automatically pop up on the internet as a person completes an Exchange application. These notices should meet the same requirements.

Besides telling people about the Exchange's determinations and the appeal rights, notices should also inform people of the importance of reporting changes that would affect their eligibility for premium credits or that could result in them paying extra taxes through reconciliation. We recommend that Exchanges notify premium credit applicants about this when they first apply, and Exchanges should send notices to enrollees at least semi-annually, if not more often, urging them to report changes in income or household size. HHS should develop and focus-test model plain language notices for this purpose and should make translated versions available.

Recommendations: The final rule should specify LEP requirements for notices, require that internet notices meet the same standards as paper notices, and provide notice about the importance of reporting changes in income or household size. HHS should develop and focus-test model notices and translated model notices for states' use.

§155.240- Payment of premiums

a. Payment by individuals

We recognize that the statute permits qualified individuals to make premium payments directly to QHP issuers if they elect to do so. In the preamble, HHS appropriately cites additional mechanisms an Exchange may employ to facilitate the payment of premiums, such as by serving as a "pass-through" between enrollees and QHP issuers or by collecting premiums and aggregating payments to issuers for their entire membership.

We believe that these alternative processes provide serious benefit to qualified individuals, issuers, and Exchanges. They would allow a consistent site for paying premiums, regardless of whether an individual's QHP changes from year to year. For issuers, having the Exchange facilitate premium collection will enable the receipt of aggregated premium payments, providing a monthly lump sum payment for all of the issuer's beneficiaries. For the Exchange, it will enable

real-time data-tracking to ensure the most accurate and up-to-date enrollment information. Therefore we believe that, similar to the provision outlined in §155.240(c) requiring SHOP Exchanges to have the ability to collect premiums from qualified employers, HHS should require Exchanges to have the capacity to collect premiums from qualified individuals.

Having multiple payment options will likely add some administrative difficulty for the Exchange, which must accurately track eligibility and enrollment of all qualified individuals. In particular, information regarding premium payment compliance of individuals paying the QHP issuer directly will have to be routed from the QHP to the Exchange, possibly hindering the Exchange's ability to maintain complete, up-to-date records on all participants. This may make it difficult to ensure that grace periods are appropriately applied and enforced. To ameliorate this problem, HHS should require that states include in their Exchange Plans how they will address any operational difficulties presented by the bifurcation of premium collection.

Recommendation: The final rule should require Exchanges to have the capacity to collect premiums on behalf of qualified individuals. HHS should require states to describe in their Exchange Plans how they will address any operational difficulties presented by having multiple methods for premium collection.

c. Payment by qualified employers

We strongly support the requirement that Exchanges accept an aggregated premium paid by a qualified employer for coverage through the SHOP. Collecting and aggregating premium payments is one of the most useful customer service functions that a SHOP can offer qualified employers, and is a critical component of any model in which employees are provided choice among multiple plans.

While the ACA specifically requires that qualified individuals be permitted to pay QHP issuers directly, such a requirement does not exist for qualified employers. Due to the concerns regarding bifurcated payment of premiums cited in our comments on §155.240(a), we believe that HHS should require that all payments for coverage through the SHOP be paid directly to the SHOP for aggregation and payment to issuers.

Recommendation: The final rule should require that all payments from qualified employers for coverage through the SHOP Exchange must be paid directly to the SHOP for aggregation and payment to QHP issuers.

d. Payment facilitation

As described in our response to Sections 155.240(a) and (c), we recommend that the Exchange be required to have the capacity to collect and aggregate premiums from both qualified individuals and qualified employers. Therefore, we recommend modifying section 155.240(d) to read, "The Exchange *must* [emphasis added] establish a process to facilitate through electronic means the collection and payment of premiums." Assuming that "electronic means" refers to the ability of consumers or employers to pay premiums via the internet, we also recommend that non-electronic means (i.e. mail and phone) also be required available methods of premium payment for qualified employers and qualified individuals. This will make enrolling in and maintaining coverage easiest for consumers, who may have individual preferences regarding how to pay premiums.

Recommendation: The final rule should modify section 155.240(d) to read "The Exchange *must* [emphasis added] establish a process to facilitate through electronic means the collection and payment of premiums." It should also require Exchanges to have capabilities to collect premiums via mail and phone.

e. Required standards

We support the requirement that Exchanges must use the standards and operating rules referenced in Sections 155.260 and 155.270 when conducting an electronic transaction with a QHP that involves the payment of premiums or an electronic funds transfer.

§155.400- Enrollment of Qualified Individuals into QHPs

a. General requirements

The rule proposes that the Exchange must accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP, notify the issuer of the QHP selected by the applicant, and transmit information necessary to enable the QHP issuer to enroll the applicant. Families USA agrees that this is needed to ensure that an applicant is successfully enrolled. However, we would like to emphasize that the Exchange should only transmit information that is essential to enabling a QHP issuer to enroll the applicant. Extraneous information that is not necessary to the enrollment of eligible applicants into a QHP should not be transmitted.

Recommendation: The final rule should state that the Exchange must only transmit information to the QHP issuer that is necessary to enrolling an applicant in coverage.

b. Timing of data exchange

With respect to the timing of the transfer of necessary information from the Exchange to a QHP issuer, the rule proposes that the Exchange must send eligibility and enrollment information to QHP issuers on a timely basis. While HHS anticipates issuing further guidance on this timing, Families USA strongly supports codifying a requirement for the specific frequency for enrollment transactions in real-time in the final rule. As soon as the technology can enable real-time determinations, redeterminations, and enrollment, Exchanges should be required to adopt the capability. If an applicant is determined eligible for coverage, the applicant should be directed to select a QHP and be given clear, understandable information regarding their different options in real-time. In other venues, consumers routinely interact with online systems that enable "real time" purchase of goods and management of registrations and renewals (for motor vehicles, for example). A true user-focused experience in the Exchange should also permit real-time interactions to the greatest extent possible.

Families USA believes that it is important for the QHP issuer to verify and acknowledge the receipt of eligibility and enrollment information to both the Exchange and the applicant. The proposed rule states that the Exchange will establish a process for the QHP issuer to verify and acknowledge the receipt of this information, but does not clearly state who the recipient of the verification is. Research with respect to Medicaid and CHIP coverage has shown that when applying for health coverage online, many people become concerned that their online application was not successfully submitted if they do not receive an email or notice of receipt. As a result, they would like to see a better system of tracking applications and clearer communications

confirming that applications are received and reviewed.[11] Therefore, it is important that both the Exchange and the applicant are notified when the QHP issuer has received and verified eligibility and enrollment information.

Recommendation: The final rule should clearly define "timely basis" for the submission of eligibility and enrollment information by codifying the frequency for enrollment transactions between the Exchange and QHP issuers in real-time. In addition, QHP issuers should be required to verify and acknowledge the receipt of eligibility and enrollment information to both the Exchange and the applicant.

§155.405- Single streamlined application

a. The application

Families USA strongly supports that this section of the proposed rule seeks to simplify and streamline the application and enrollment process for QHPs, premium tax credits, cost-sharing reductions, Medicaid, CHIP, and, where applicable, the Basic Health Program. This will make it easier for applicants to complete the application and enroll in health coverage.

It is essential that the application be easy to complete for a variety of applicants with different characteristics, such as different health needs, family compositions, incomes, literacy levels, and languages. Families USA recommends codifying the statement in the preamble of the proposed rule, which is also a requirement of Section 1413 of the statute, which reads: "[the] single, streamlined form…must be structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for the programs." Families USA believes that in order to enroll all applicants in coverage, the application must be accessible to a variety of audiences, including people with LEP and people with disabilities. The application must be written in plain language at an appropriate reading level and should be focus-tested with a diverse consumer group, including LEP individuals and people with disabilities. The written application, both paper and electronic, should be translated in all languages where the lesser of five percent of the population or 500 LEP individuals in the service area speak the language. If there are fewer than 50 people in a language group that reaches the five percent trigger, the application does not have to be translated but must at least have a tagline in the primary language of the group providing notice of the right to receive competent oral interpretation of those written materials free of charge. The application should be translated according to recognized standards by qualified and competent translators and not by "machine" translation, as described in our comments on section 155.205. The standard for in-person and telephone applications should be that oral language assistance be provided in an adequate and timely fashion to everyone requesting assistance. This could include using a language line.

In addition, we recommend that the online version of the application give users the option to create an account and save their work so that they can start and stop filling out the application multiple times without losing their work. This would allow applicants to begin an application on their own and share it with an application assistor if they need help.

HHS seeks comment on whether to codify the requirement that applicants not be required to answer questions that are not relevant to the eligibility and enrollment process. Families USA

believes that it is crucial that the application solely ask for information necessary to eligibility and enrollment. Research shows that the enrollment process for Medicaid and CHIP is often the greatest barrier to enrollment, and that long, detailed applications that request extraneous information prevent applicants from successfully enrolling in coverage.[12] In the preamble of the proposed rule, HHS states: "Our intent is to simplify the application process and reduce, if not eliminate, the collection of extraneous information." Given the intent of the proposed rule, we urge HHS to codify a requirement in paragraphs (a) and (b) of Section 155.405 that applicants must only be required to provide the minimum information necessary to determine eligibility, regardless of whether an Exchange uses the model application provided by HHS or an alternate application. In addition, we recommend that the final rule state that paper documentation should only be requested from applicants if the necessary information cannot be obtained from electronic data, self-attestation, or other databases.

The preamble of the proposed rule also states: "HHS plans to create both a paper-based and web-based dynamic application." Families USA supports the use of dynamic questioning, as it will build upon the dynamic questioning that many states currently use in their online Medicaid and CHIP applications to ensure that applicants are only asked questions that are relevant to their own characteristics and needs, making it easier for applicants to secure coverage.

Families USA supports the option for individuals to apply for coverage using a paper application. It is crucial that the paper application is simple and streamlined, as is required for the web-based application. The paper application must allow for three distinct eligibility determination and enrollment activities: eligibility determination and enrollment into an insurance affordability program (such as Medicaid or a premium tax credit), eligibility determination for unsubsidized Exchange coverage, and enrollment into a QHP with the transmission of necessary information to an insurer. It is crucial that the paper application forms request the minimum amount of information required to enroll the applicants in the coverage they are seeking. In addition, HHS should consider how and where the paper applications should be submitted. We believe that applicants should be able to submit the paper application to any insurance affordability agency, including the Medicaid, CHIP, and Exchange agencies, as well as any other state insurance affordability program agencies.

Recommendation: The final rule should codify the statement in the preamble that reads: "[the] single, streamlined form…must be structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for the programs." The final rule should clarify that the single streamlined application (both online and on paper) must be accessible for people with LEP (according to specific standards) and people with disabilities, and it should be written in plain language at an appropriate reading level. The final rule should also require that the web-based application give users the option to create an account and save their work to access at a later time.

We also recommend that the final rule codify a requirement in paragraphs (a) and (b) of Section 155.405 that applicants must only be required to provide the minimum information necessary to complete an eligibility determination, regardless of whether an Exchange uses the model application provided by HHS or an alternate application. Paper documentation should only be requested from applicants if the necessary information cannot be obtained

from electronic data, self-attestation, or other databases. Paper applications, like web-based applications, should only request the minimum amount of information necessary for enrollment.

c. Filing the single streamlined application

Families USA strongly supports that this section of the proposed rule allows for "an applicant," "an authorized representative," or "someone acting responsibly for the applicant" to file the streamlined application. It is important to allow representatives to act on behalf of applicants in situations where applicants cannot apply on their own. As further guidance is developed, HHS may want to consider what information should be required from individuals "acting responsibly for the applicant," such as contact information and declaration of relationship to the applicant, to prevent fraud and mistakes.

Families USA strongly supports that the single streamlined application can be submitted through several pathways, including online, by phone, by mail, and in person. Applicants will have different needs and will require different levels of assistance, making all of these avenues of applying for coverage necessary. Having several pathways to apply for coverage will help maximize successful enrollment. HHS solicits comment on the requirement that an individual must be able to file an application in person. Families USA feels that it is crucial to allow applicants to submit an application in person, as consumers will have varying levels of access to the internet and comfort applying for coverage online, over the phone, or by mail.

Families USA supports that applicants should be given notice of how their information will be used before it is collected on the application for coverage. However, it is important to minimize application instructions and introductions and write all user agreements and disclosures in plain language. Long or complicated disclosures will likely deter some people from continuing the application process, and may cause unnecessary concern about the extent to which they will be asked to divulge personal information (particularly given that the majority of the information needed to make an eligibility determination has already been collected by the federal or state government and/or already exists in third-party databases). Therefore, it is important to inform applicants of how their information will be used, but disclosure should be short and written in basic language.

Recommendation: Families USA encourages further discussion on what information should be required from individuals "acting responsibly for the applicant" in order to prevent fraud and mistakes. We recommend that the final rule give the applicant the option of applying for coverage in person. We agree that applicants should know how their personal information will be used before providing, but we urge HHS to require that disclosures on applications are short and in plain language.

§155.410- Initial and annual open enrollment periods

Initial period and effective date

We support making the initial open enrollment period as long as possible. It will take time for people to learn about their new health coverage options initially and enroll. A long initial enrollment window will also give Exchanges time to work through any problems as their systems first go into operation and will allow time for outreach efforts.

The proposed rule sets up an extended initial open enrollment period that ends February 28, 2014. We recommend two modifications: (a) allow either states or the federal government to extend the initial open enrollment period if they find they are not reaching enrollment targets; and (b) extend the initial period at least until March 31, 2014, which would provide people the right to enroll in coverage up until the point when they could face a tax penalty for being uninsured. We also note that it will be important for Exchanges to launch their Navigator programs before the initial enrollment period begins.

We understand the importance of deadlines to prevent people from delaying enrollment. Deadlines will also help outreach efforts as they give "hooks" to the media to publicize the new health care options and the importance of enrollment. The statute already provides a deadline to avoid tax penalties, and it makes sense to put this March 31 deadline into the regulations. We have some comments (discussed in the subsection below) about whether people should have another opportunity to enroll when they file their taxes – even if they are still subject to some penalties. Whatever the initial deadline, the rules should provide for an extension of the deadline if enrollment targets are not met and the federal government and state Exchanges need an opportunity to conduct further outreach and remedy any unforeseen enrollment problems. Announcement of such an extension would provide a further opportunity to educate people about their new rights and responsibilities.

During the initial enrollment period, the proposed rules specify a coverage start date of January 1, 2014 for QHP selections made by December 22, 2013. Otherwise, coverage would start on the first day of the following month for selections made by the 22nd of the month, and either the first day of the following month or the first day of the second following month for coverage selections made between the 23rd and the last day of the month. This could result in a real delay in coverage, particularly for people who come into the Exchange after January 1, 2014 and make their QHP selections toward the end of the month. To prevent enrollment delays, individuals should be able to start coverage on the first of the month following the month in which they make their QHP selection.

We understand that plans may not be able to immediately process enrollments and that allowing individuals to enroll in a QHP right up to the last day of the month for coverage starting the first day of the following month could pose some challenges. However, there are a number of measures that Exchanges and QHPs can take to ensure that enrollment is smooth and that individuals who need to seek care immediately can still do so. For example, once individuals make their QHP selection, they could be allowed to print a temporary insurance card that can be used when they seek care and used to verify to providers that the plan would retroactively pay the claim once plan enrollment is processed.

Recommendations: The final rule should extend the initial open enrollment period until at least March 31, 2014. It should further allow Exchanges and HHS to extend this deadline if enrollment does not meet targets. HHS must ensure that Navigator programs are established prior to the start of the initial open enrollment period. In addition, the final rule should change the effective start date of coverage so that people who make a QHP selection by December 31, 2013 are guaranteed effective coverage on January 1, 2014. For QHP selections made on or after January 1, 2014, coverage should be effective on the first

of the following month.

Subsequent annual enrollment

The proposed rules provide for subsequent annual open enrollment periods October 14 through December 7th. We agree that there are some advantages to setting this annual enrollment period at the same time as Medicare's annual enrollment period and to coincide with many employers' open enrollment season. However, because premium credits and the responsibility to purchase insurance under the ACA are built into the tax code, people will also naturally consider their obligation to purchase coverage when they file their tax returns. Further, when they file their tax returns, individuals will have better information about their most recent year of income. We therefore urge HHS and IRS to further explore whether there should be an enrollment period that better coincides with tax filing season. Such a period could allow Exchanges to automatically populate premium credit applications with information from the most recent year of electronically filed tax returns, much as student loan applications now use that information. People seeking premium credits would still need to update their income information to avoid reconciliation, and the application should prompt them to do so. The filed tax return could be considered enough to verify their approximate income for advance tax credit purposes.

Recommendation: HHS and IRS should further explore the possibility of an annual open enrollment period that coincides with tax filing season.

§155.420- Special enrollment periods

Section 155.420 establishes special enrollment periods for individual Exchanges, and section 156.285 establishes similar periods for SHOP Exchanges. We support these provisions, but recommend (1) that timing be adjusted for some special enrollees to avoid gaps in coverage; (2) the addition of several other situations for special enrollment rights; and (3) that special enrollees be allowed to change coverage tiers, at least in some situations.

b. Effective dates

Generally, special enrollees will be entitled to coverage effective on the first day of the month following QHP selection. However, under the proposed rules, special enrollees who select a QHP after the 22nd of a month may have to wait until the first day of the second following month for their coverage to be effective. The rules appropriately make exceptions for newborns and adoptions to ensure that children will have immediate coverage. However, we are concerned that the timing will leave other people with gaps in coverage. For example, if someone suddenly loses a job that provided coverage and has no COBRA right, he or she could be without coverage from the 23rd of one month until the first day of the second following month. This is very concerning considering that we saw many cases of sudden layoffs during the recession. Further, people newly eligibly for premium tax credits may also have to wait over a month for coverage to be effective.

Another concern is that a person losing Medicaid or CHIP could be subject to an enrollment delay under the proposed rules. This is inconsistent with the statutory goal of seamless eligibility and enrollment, and could cause grave problems for a low-income person in the midst of a course of treatment. Medicaid programs are now designed to provide retroactive coverage to applicants at least to the first day of the month of the application, and Exchanges should similarly be able to

implement continuous coverage systems. Exchanges should be required to allow new and special enrollees to print out temporary insurance cards that would verify to providers that the plan will retroactively pay the claim once plan enrollment is processed. Further, HHS should design a fallback enrollment system to ensure that people losing Medicaid or CHIP coverage will not experience any gaps in their coverage until their coverage under the Exchange becomes effective. Several years ago, HHS contracted with a third party to provide temporary drug coverage to low income Medicare Part D beneficiaries until enrollment glitches could be resolved.

Recommendation: To prevent enrollment gaps, we recommend that the final rule give special enrollees the *option* of coverage effective the date that they lost other coverage, provided they pay premiums back to that date. We stress that this should be an option and not a requirement, since some special enrollees may face financial difficulties in making retroactive premium payments. Further, Exchanges and QHPs should allow people to begin the special enrollment process in advance of a known special event to avoid an enrollment gap. HHS and/or Exchanges should devise temporary systems for paying claims until a QHP is able to process new enrollment.

c. Length of special enrollment periods

This section provides a qualified special enrollee with 60 days from the date of a triggering event to select a health plan. 60 days is an appropriate window for special enrollment, but people should be able to begin this process in advance of the triggering event in order to avoid coverage gaps.

Recommendation: **The final rule should specify that Exchanges and QHPs must allow special enrollees to apply for coverage in advance of a known event that will trigger a special enrollment period.**

d. Special enrollment periods

This section sets forth the various triggering events that allow for a special enrollment period. It provides special enrollment periods for people and households losing other "minimum essential coverage" or gaining a dependent and for Native Americans, consistent with the statute. It also appropriately lists other situations that may arise midyear and should allow a person to enroll in a QHP, including when a person gains citizenship or lawfully present status, when errors or misrepresentations about Exchange eligibility caused non-enrollment or enrollment in a QHP, when a person moves into a new service area, when a QHP violates a material provision of its contract, when a person becomes newly eligible for premium credits or there is a change in a person's eligibility for cost-sharing reductions, or in other exceptional circumstances provided by the Exchange or HHS. The preamble mentions natural disasters as one exceptional circumstance, and support this since emergency temporary relocations due to storms have necessitated plan changes in the past. We support the broad language in (d)(9) ("other exceptional circumstances"), and suggest that the final rule clarify that this allows for special enrollment if there are major changes in an insurance market or if an Exchange needs an additional period to encourage enrollment.

Under (d) (1), a special enrollment period occurs if an individual or dependent loses minimum essential coverage. In the Act, minimum essential coverage is defined as Medicaid, Medicare Part A, CHIP, Tricare, VA health care, Peace Corps health plans, eligible employer-sponsored

plans, individual market plans, grandfathered plans, or other coverage such as a high-risk pool. The regulation should refer to the definition of minimum essential coverage that applies to this section, and to the definition of dependent that applies to this section.

The final rule should also clarify that a person losing any of those sources of coverage qualifies for special enrollment. That is, if an individual has two of the sources of coverage on the list and lose one of them, he or she will still qualify for special enrollment. This clarification is necessary because some of the sources of coverage are skimpy. For example, AmeriCorps plans currently have low annual limits, and grandfathered plans may not provide adequate coverage.

If a person loses the employer's contribution to an employer-sponsored plan, the individual should also qualify for special enrollment whether or not he or she qualifies for premium credits. (In this instance, COBRA should be considered an employer-sponsored plan.) For example, COBRA can be prohibitively expensive, and we anticipate that people who cannot afford COBRA will need special enrollment rights for a QHP. Under (d)(6), people for whom employer-sponsored plans are no longer affordable get a special enrollment right prior to the employer's upcoming plan year, but COBRA-eligibles will need such a right earlier. The preamble discusses loss of employer-contributions as a triggering event, but this is not clear in the regulation itself. The regulation should include some clarifying examples.

Under (d)(2), a qualified individual becomes eligible for a special enrollment period if he or she gains a dependent through "marriage, birth, adoption or placement for adoption." Only some states currently permit same-sex marriage, but other states allow for other arrangements, such as civil unions or registered domestic partners, for same-sex partners who are not permitted to marry. This section should be expanded to include such arrangements as well. It should allow for special enrollment of people who become new dependents under state law or under the terms of the plan.

Under (d)(4), a qualified individual becomes eligible for a special enrollment period if his or her 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 or HHS." This exception for inadvertent or erroneous actions should not be limited to those situations where the error can be traced to an Exchange or HHS employee. If an enrollment or non-enrollment is truly the result of an erroneous or inadvertent action, an exception should be made and a special enrollment period triggered. This could easily be corrected by changing the "and" in (d)(4) to "or."

Under (d)(5), a special enrollment right is provided to people who can demonstrate that their QHP has violated a material provision of its contract with them. We support this and recommend that the final rule additionally state that individuals in a QHP that has been decertified by the Exchange or is undergoing review for decertification should also have a special enrollment right.

Under (d)(6), special enrollment is available to people "determined newly eligible or newly ineligible for advance payments of the premium tax credit…" We recommend clarifying that the special enrollment right is triggered by the Exchange making a *determination*, not the date that an individual's income actually changed. It would be an unnecessary burden on Exchanges and plans to have to calculate special enrollment periods based on when the person's income actually

changed enough to alter credit-eligibility. Further, the intent of the Affordable Care Act is to provide affordable health care for all Americans. We anticipate that it will take time to reach people who previously could not afford coverage and inform them of the availability of premium credits in the Exchange, and continuous enrollment for the population eligible for credits will help to get them into coverage. Tax penalties for failure to maintain coverage will dissuade people from intentionally delaying enrollment, making any further restrictions on enrollment unnecessary for the credit-eligible population.

Further, we recommend the inclusion of three additional qualifying events:

1. People with disabilities who have COBRA coverage should be able to select a QHP when their premiums rise to 150 percent of standard rates (the COBRA disability extension). This is a time when QHPs may become more affordable than COBRA.
2. Pregnancy should trigger special enrollment. Otherwise, pregnant women may be stuck in grandfathered plans that do not provide adequate maternity coverage. Further, a pregnant woman may reasonably anticipate that the addition of a household member will eventually qualify her for premium credits, and she should be able to enter a plan that can provide continuous coverage during the pregnancy and postpartum period.
3. End of incarceration: At the end of a period of incarceration, a person may be eligible to participate in the Exchange and receive premium credits. We suggest that HHS consult with entities active in integrating ex-offenders into the community to determine at what point in the release process people will likely get help enrolling in a health plan and need to execute enrollment to avoid a break in care. HHS should time the special enrollment period for this population accordingly. HHS should seek to avoid any gaps in coverage for this population, especially since continuity of medications may be critical.

Recommendation: The final rule should clarify that a person losing any source of minimum essential coverage is entitled to special enrollment, even if they had multiple coverage sources previously, and make loss of an employer's contribution to employment-based coverage a qualifying event (including the loss of a contribution that occurs when someone leaves employment and becomes eligible for COBRA). It should also clarify that the definition of a dependent includes dependents under state law or plan rules, and that civil unions (where permitted) are treated as special events like is marriage. The final rule should clarify that the date that the Exchange completes an eligibility determination regarding premium or cost sharing credits begins the special enrollment period for someone qualifying for assistance. Finally, it should add special enrollment periods for people reaching the COBRA disability extension period, pregnant women, and people leaving incarceration, with examples illustrate these situations.

<u>e. Loss of coverage</u>

Section (e)(1) explicitly excludes people who lose COBRA coverage due to failure to pay premiums on a timely basis from special enrollment. We oppose this exclusion and believe that such individuals must be granted special enrollment rights in the final rule. They may be among those newly qualifying for premium credits, or they may have elected COBRA without understanding that they could get more affordable coverage through a QHP. Further, excluding individuals for whom COBRA premiums become too expensive from special enrollment rights creates a disincentive for enrollment in COBRA coverage.

Recommendation: The final rule should eliminate Section 155.420 (e)(1).

f. Limits on special enrollment periods

This section prohibits special enrollees from changing tiers of coverage, unless they have become newly eligible for a premium tax credit or there was a change in their cost-sharing subsidy level. We believe that people will have valid reasons for changing coverage levels due to other special enrollment events. All events that trigger a special opportunity to enroll imply a significant change in circumstances. For example, even for households that are not entitled to subsidies, the addition of a dependent will significantly change the household's finances and the family may therefore need to adjust its coverage tier to fit its budget. Or, a pregnant woman or a household that has a new dependent with a special health care need may need more comprehensive. Further, a person who received misinformation about QHPs may also have received misinformation about coverage tiers. Therefore, all individuals eligible for special enrollment should be permitted to choose their coverage tier if they choose.

Recommendation: The final rule should eliminate the prohibition on changing tiers of coverage during a special enrollment period.

Information about special enrollment rights

The proposed rule does not provide for any notices about special enrollment rights. It is therefore unclear how people will find out when they are entitled to special enrollment prior to the expiration of the 60-day special enrollment period. Exchanges should be required to notify people of their special enrollment rights when they report an income change or other life change that would trigger special enrollment. Exchanges should also provide all new enrollees and applicants with general information about special enrollment periods and maintain information about special enrollment rights on their websites. Employers should modify their COBRA notices to also include information about special enrollment in QHPs. Employers that are terminating group plans or reducing or eliminating their contribution to group plans should notify enrollees that they may be entitled to special enrollment. Medicaid/CHIP agencies should notify people of their possible Exchange eligibility and special enrollment right prior to the end of the public program eligibility period.

Additionally, we note here, as well as in our comments on the premium credit rules, that the proposed affordability test for minimum essential coverage could cause a problem for people whose employer-based coverage is unaffordable for part of a plan year that does not correspond with a calendar year, but then becomes affordable in January. The person does not have a special enrollment right in the employer plan at that time, yet is no longer qualified for premium credits on the Exchange. (See example 6 in 1-36B-2.) This problem must be addressed in final rules.

Recommendations: The final rule should include requirements that Exchanges, employers, and Medicaid/CHIP agencies provide notice of special enrollment rights at appropriate times.

§155.430 Termination of coverage

We support the requirement that Exchanges must determine the form and manner in which coverage is a QHP is terminated. The list of termination events in the proposed regulation is

appropriate. In subsection (c), the proposed rules require QHPs to maintain records of termination and track the number of terminations. We recommend that they also track the reason for termination and submit that information to both HHS and to the Exchange.

We very much support the requirement that QHPs provide reasonable accommodations for people with the conditions and disabilities specified in subsection (3) and we recommend that the final rule add that plans may establish reasonable accommodations for other people with special needs or circumstances. For example, if a family notifies a QHP that it needs additional time to pay premiums due to an emergency and the QHP concurs that this is reasonable, or if a charity notifies a QHP that it is processing payments for someone facing a sudden hardship, the QHP should be allowed to delay termination.

We support the proposal that enrollees be allowed to voluntarily terminate coverage on a date that they specify. People must be allowed to promptly terminate their coverage in a QHP so that they will not continue to receive advance premium payments when a change in their circumstances renders them ineligible. Exchanges and/or QHPs should provide people with documentation of termination for tax purposes.

Reading section 156.270 and section 155.420 together, we recommend that the final rule clarify what notices a person will receive prior to termination for nonpayment of premiums, and that the final rule include a section regarding underpayment of premiums. Enrollees who do not make payments and fail to pay by the conclusion of their grace period should receive several notices of nonpayment and potential termination. Utilities, telephone and cable companies routinely send out multiple notices prior to a termination, and health plans should similarly give consumers every opportunity to prevent termination. First, each month that their premiums are unpaid, enrollees should receive notice of the amount of premiums due, that premiums are overdue, that their enrollment may be terminated if they do not pay their premiums by the conclusion of the grace period, and that they should notify the Exchange or QHP if they are intending to terminate their enrollment so that they will not continue to receive advance premium credits. Second, a month before termination will be effective (using the time frames in section (4)), people should receive notice that termination is about to occur. This notice should include the reason for termination, a citation to the regulation, information about the possible consequences of not maintaining minimum essential coverage, and information about appeal rights and available consumer assistance. Both types of notice should meet the standards for language access that we recommend throughout our comments.

Recommendations: The final rule should require that Exchanges track reasons for termination. It should allow plans to provide reasonable accommodations for other individuals besides those named in the proposed rule. Finally, it should require multiple notices to enrollees prior to termination for nonpayment that inform people of the consequences of nonpayment and not maintain coverage and their rights.

Subpart H- Exchange Functions: Small Business Health Options Program (SHOP)

We support the overall goal of increasing the choice of affordable health care options for small business owners and their employees. The SHOP presents the opportunity to increase choice for employers who wish to provide employees with one or more health plan options. The SHOP's

potential for providing enhanced customer service functions for employers facilitates the opportunity for a broader array of plan options for small business workers, as it may allow for easier transactions with multiple carriers, which would currently pose considerable administrative burden on small business owners.

However, while increased choice is an important principle, we believe that choice should be meaningful, reasonable, and not excessive. It has been shown that an excessive number of product options can be overwhelming to consumers and employers, who ideally want several high quality options that offer good value from which to choose. Additionally, greater choice for each small business employee presents the possibility of adverse selection, where older or sicker employees may gravitate to higher cost plans while younger or healthier individuals may concentrate in cheaper plans. Greater choice within a small group may also prevent adequate protection against premium discrimination for older workers, as describe in greater detail below. As such, we believe that HHS should caution states or Exchanges that wish to pursue high levels of open choice in the SHOP, particularly if that choice exists across all tiers of coverage. States and Exchanges legally have the option to implement such a model, but should evaluate and prepare for the potential impact on risk selection and age discrimination that may result if employees of the same business are dispersed across multiple health plans.

§155.700- Standards for the establishment of a SHOP

Consistent with the ACA, this section requires an Exchange to develop a SHOP Exchange that will connect employers with between 2 and 50 employees with QHPs. SHOPs are a critical link in the ACA's expansion of health coverage and they should be developed with the goal to maximize the participation of small employers. This can be best accomplished by building on, and in some cases mirroring, the work being done to develop the Exchanges that will serve the individual market. SHOPs must also be developed in a way that takes into account the reality that shopping for and purchasing health coverage for employees of small employers involves very different considerations than it does for large employers. In our comments below we offer suggestions that will help make it desirable for small employers to purchase health coverage through the SHOP, make employer and employee interaction with the SHOP a positive experience, and lay the groundwork to allow states expand their SHOPs to serve larger employers and/or merge their small group and individual markets.

Functions of a SHOP §155.705

a. Exchange functions that apply to SHOP

While the SHOP will have many of the same purposes and functionalities as the Exchange, we agree there will be certain Exchange functions that need not also be required of the SHOP. We believe the one excluded function of the Exchange in the proposed rule that *should* be required of the SHOP in the final rule is a premium calculator that is displayed on the SHOP website. The preamble encourages SHOPs to develop such a calculator, but we believe the benefit to employers and employees will be significant enough (with a minimal design burden) to necessitate it as a requirement of SHOP certification.

Employers will have a multitude of decisions to make about the coverage they offer their employees, beginning with whether to purchase coverage through the SHOP. A premium

calculator will be most beneficial if it allows an employer to compare the cost of covering employees across plans and plan tiers. The calculator should have the capability to take into account the small employer tax credit for which certain small businesses will qualify.

There will also be a benefit to employees from access to such a calculator even though they will not qualify for the individual premium tax credits. A calculator would help employees to make an informed decision about which offered plan to select by allowing them to compare their potential premium costs for benefits covered. Additionally, as some individuals will move between coverage in the Exchange and the SHOP, there are benefits of familiarity if a premium calculator exists for both entities.

Unique functions of a SHOP §155.705 (b)(2); (b)(3)

The proposed rule codifies the statutory requirement that the SHOP Exchange permit employers to select a plan level from which their employees may choose a plan. We support the provision allowing SHOP Exchanges to present employers additional choices when selecting the menu of plans to offer their employees – including offering one QHP, offering several QHPs, or allowing employees to choose any available SHOP QHP – provided that HHS requires SHOPs to address two issues: the potential for adverse selection and possible age discrimination in premiums charged to older employees.

While we support efforts to increase choices for small business employees, we are concerned about the risk of adverse selection both within a group and across the SHOP overall. As the preamble recognizes, if an employer offers plans across multiple precious metal levels, it is possible that older or sicker employees may select more costly comprehensive plans (e.g. gold or platinum plans) while younger or healthier employees will predominantly choose the cheapest option (e.g. bronze or silver plans). If this pattern is consistent across most or all groups entering the SHOP Exchange, such a concentration of higher risk could result in the gold and platinum tiers exhibiting upward spiraling costs over time, eventually becoming unaffordable to employees for whom they are the best option. This phenomenon would greatly impact older or sicker employees, especially in scenarios in which the employer is providing a flat dollar amount (i.e. defined contribution) to all employees (which may violate existing age discrimination laws); the escalating costs in the higher tiers would disproportionately affect older and sicker employees.

Even if an employer offers plans only within one tier of coverage, there is still a potential for risk selection. Certain plans within a tier may be more attractive to younger, healthier workers, leaving only older or sicker workers in other plans. The potential for this problem illustrates the need for very strong marketing standards and other protections to ensure uniformity across plans so that carriers cannot easily "cherry pick" only the healthiest enrollees. The preamble recognizes the potential risk selection problems of allowing employee choice across all tiers of coverage. We recommend the preamble also recognize the potential for risk selection *within* a tier and describe that this problem should be mitigated not just through risk adjustment, but through very strong marketing standards and other protections against cherry picking.

Also of concern is the potential for age discrimination, regardless of whether an employer picks one plan, one plan level, or another menu of options for his or her employees. Since QHPs will be permitted to age adjust premiums up to a 3:1 ratio, older employees may face a higher premium as compared to their younger colleagues, even if selecting the same QHP. Typically in

the current small group market, each group is provided a uniform composite rate for all employees based on the underwriting of the entire group, thus there is no difference in premiums between older and younger employees within a single employer.

In the SHOP, if an employer elects to provide a defined contribution amount to all employees, older employees would be left to cover a larger share of their health care costs, both in terms of actual dollars and percentage. For example, if an employer promised to contribute $150 per month to each employee's premium, a 20 year old whose premiums might be $250 would only have to pay $100, while 60 year old, whose premiums may be up to three times that of his younger colleague, could be saddled with $600 of a $750 monthly premium. Such a scenario may violate age discrimination protections for employees.

One way to mitigate this is to require the SHOP to facilitate the establishment of a composite rate for a SHOP employer group, similar to the rate setting used in the current small group market. In such a scenario, an employer's rate(s) would be established by calculating the total cost of coverage for all employees, taking into account the age distribution of the group. The employer can then decide to cover a portion of the total cost and distribute the remainder of the costs equally to all employees regardless of age. While SHOPs will require QHPs to lock in *age-adjusted* rates for a 12-month policy year, to effectively employ this model, the SHOP would need to require that the QHP be locked into that *composite* rate for the group for 12 months to accommodate any new employees that may join the group mid policy-year. It is easy to imagine how this strategy would work when an employer offers one plan— or perhaps even two to three plans depending on the size of the group. However, to establish a composite rate for a group if employees are distributed across many QHPs in a model with extensive choice is far more challenging.

To prevent age discrimination in an employee choice model of plan selection, the SHOP should be required to provide a mechanism for calculating employee premiums that eliminates or mitigates the effects of age on individuals' premiums. The SHOP could adopt a model similar to that employed by the Connecticut CBIA Exchange, in which the Exchange provides the opportunity to set a contribution amount as a percentage of the employer group's composite rate for any given family category of a "reference" plan. All employees then pay a uniform flat rate for a given family category in that reference plan. Employees that want to purchase an alternative plan are responsible for paying the dollar amount of their uniform contribution in the reference plan, plus or minus the difference in age-rated premiums between the reference plan and alternative plan. Employers pay the remaining cost of the employee's age-adjusted premium for the alternative plan. Using such an approach, older employees receive a larger dollar contribution than their younger colleagues when purchasing an alternative plan because their age-adjusted premiums are higher. Further, an employer's total dollar contribution remains the same, regardless of which plans his employees choose. This method would mitigate the impacts of age rating for older employees, as well as ensure predictability for the employer in terms of anticipated health costs. For a complete description of this model, see "Rick Curtis and Ed Nueschler, *Small-Employer ("SHOP") Exchange Issues* (Washington: Institute for Health Policy Solutions, June 2011).

Alternatively, the SHOP could offer employers the opportunity to set a contribution amount as percentage of *the age-adjusted cost* of a benchmark or "reference" QHP. Employees would then

be able to use that contribution towards the purchase of any QHP permitted by the employer, with older employees receiving a larger actual dollar contribution than their younger colleagues because of the larger premiums set for older participants. While this would not completely eliminate any differences in premiums between employees of different ages, it would minimize such difference. For example, an employer can provide employees with 80% of the cost of the premium for employees if they select a certain silver level plan identified by the employer. An employee 20 years old may face a premium of $200/month for the benchmark silver plan, while an employee 60 years old might be rated at $600/month. The employer would provide 80% - or $160/month in the case of the younger employee and $480/month for the older one. Either employee can select to choose a different plan (among those available to the employee based on the number of plans offered by the employer), with the employee bearing any difference in price. This would provide predictability for the employer in terms of anticipated health care costs, while also minimizing discriminated against based on employee age.

The preamble to section 155.705(b)(3) solicits comments on whether minimum participation rate requirements should be applied in SHOPs, and if so, how the rates should be calculated and what that rates should be. As the preamble recognizes, minimum participation rules serve to mitigate the risk of adverse selection in group plans by requiring a larger, diverse segment of a group to enroll in coverage. The need for such a requirement will lessen due to various ACA provisions, including the individual responsibility requirements, potentially warranting a waiver of these requirements in the SHOP Exchange. However, if minimum participation rules are applied to the SHOP, we recommend that any rate calculation excludes from the count of eligible employees those who already have creditable coverage, such as through a spouse's health plan, Medicare, or Medicaid. For example, if a 75 percent minimum participation rate is established, the requirement should be considered to be met by the participation of 75 percent of *uninsured* workers in a group. Such a method of calculating employee participation would ensure that employers are not restricted from offering coverage to workers through the SHOP, helping to meet the goal of maximizing SHOP participation among small employers.

Recommendation: The SHOP must be required to develop and provide a premium calculation mechanism that mitigates the effects of age-rating on individual workers so that they are not exposed to a new form of discrimination in the Exchange. In addition, the preamble should be modified to include a discussion of potential risk selection *within* plan tiers. If minimum participation standards are included in the final rule, their calculation should not include workers who have alternative sources of coverage such as spousal coverage, Medicare, or Medicaid.

<u>Unique functions of a SHOP §155.705(b)(4)</u>

We support the requirement that SHOPs must offer certain customer service functions for small employers, including providing employers with an aggregated monthly bill and collecting an aggregated premium payment from employers to distribute to the appropriate QHPs covering the employees. However, if a SHOP elects to permit employers to pay monthly premiums to QHPs directly, the SHOP should not be required to send aggregated monthly bills or provide aggregated billing to such employers. A requirement to do so would pose an unnecessary and unworkable administrative burden on the SHOP with little or no added benefit since an employer paying QHPs directly would be receiving monthly bills from the issuers and sending separate checks to the insurers directly. One way to avoid this potential bifurcated situation between employers

who pay the SHOP and those who pay issuers directly would be for HHS to prohibit SHOPs from permitting the latter practice. While the statue explicitly provides individuals the right to pay QHP issuers directly rather than the Exchange, no such right is explicitly conferred to small business enrollees in the SHOP. Additionally, there is little to no value for small businesses to do so; in fact, the SHOP's ability to aggregate payments for employers offering multiple QHPs presents a significant benefit of practical efficiency for employers and insurers.

Additionally, the preamble to section (b)(4) states that HHS anticipates that, "most SHOPs will also include the employer and employee contribution for the QHP selected by each employee as a service to employers." We recommend that this function be formally required of SHOPs, as it will increase the usefulness of a monthly aggregated bill to employers, who will then be able to collect premium shares from workers and understand their business costs for providing worker coverage more easily.

Recommendation: The final rule should require that all participants in the SHOP pay all monthly premiums to the SHOP directly. If employers are permitted to pay QHPs and not the SHOP, then HHS should clarify that SHOPs do not have to send aggregated monthly bills to or collect aggregated premium payments from employers opting to pay QHPs directly. Additionally, the final rule should require that aggregated SHOP bills include the employer and employee premium contribution.

Unique functions of a SHOP §155.705(b)(6)

We strongly support the requirement that plans may not vary rates for a qualified employer during its plan year. We agree with the statement in the preamble that, "if an employee is hired during the plan year or changes coverage during the plan year during a special enrollment period, the rates set at the beginning of the plan year must be the rates quoted to the employee."

Additionally, we support the requirement that SHOPs must set a uniform policy for the frequency with which QHP rates may be changed for newly sold coverage. Typically, small group markets in many states experience changes in plan rates either monthly or quarterly. We believe that HHS should require SHOPs to permit rate changes only quarterly. Doing so would align rate changes between the SHOP and the outside small group market which often has rate changes on a quarterly basis. Permitting monthly rate changes would add administrative burden for the SHOP, which must collect and display up-to-date premium rates. Further, monthly premium increases for SHOP coverage could jeopardize the integrity of risk adjustment, rate review, and medical loss ratio calculation processes. Also, since employers will need to first select a menu of plans to offer employees and employees will need a reasonable open enrollment period in which to make a plan selection, it is probable that a small group insurance transaction will take more than 30 days. As such, an employer should know that the rate(s) initially presented will remain the same when the transaction is eventually completed and plans are selected. Requiring plan rates to remain constant for a quarter will promote such consistency.

While an annual frequency for QHP rate changes appears very suitable in the Individual Exchange, it appears inappropriate for the SHOP. Because the SHOP will adopt a rolling, year-round application process for new groups, and since plans will be required to lock in rates for a 12-month policy period with each group, an annual limitation on rate increases would greatly limit plans' abilities to adjust rates in a reasonable time period. If such a limitation was placed on

issuers, it is likely that initial and subsequent rates would be increased to adjust for this uncertainty and reduced frequency of rate adjustments.

If HHS ultimately decides to adopt a policy difference from setting small group plan years based on the date of enrollment, then the frequency of rate changes may need to be adjusted accordingly. For example, if HHS chose to align the SHOP plan year with the Individual Exchange, then an annual rate change cycle for QHPs would be appropriate. Alternatives to the 12-month rolling admission are discussed elsewhere in response to 155.725(b), which include setting the SHOP plan year to the calendar year, but allowing midyear entrants to the SHOP to have a pro-rated contract year until the next calendar year open enrollment.

Recommendation: The final rule should state that QHPs in the SHOP may not raise rates for newly sold coverage more often than quarterly.

Unique functions of a SHOP §155.705 (b)(7)
We support the rule's statement that, in a merged small group and individual Exchange, QHPs for small businesses must still meet the deductible limits that apply uniquely to small group coverage. Further we support the preamble statement that the Exchange or the employer may still limit the tiers or QHPs available to workers in a merged market.

Eligibility standards for SHOP- §155.710

b. Employer eligibility requirements
This section codifies that only small employers may obtain coverage through a SHOP. We support the interpretation that small employers include those with between 2 and 100 employees (or between 2 and 50 employees in states that elect to wait until 2016 to adjust the upper limit of the small group definition to 100), but do not include sole proprietors or otherwise self-employed individuals who constitute a group of 1 (along with any family members that would be included in a family policy). Requiring sole proprietors or otherwise self-employed individuals to obtain coverage in a SHOP rather than an Exchange would prevent many individuals from receiving income-based premium tax credits or cost-sharing subsidies that are only accessible via the Exchange. Furthermore, it would pose an administrative burden for individual Exchanges to screen out individuals based on their status as a sole-proprietor.

Because some sole-proprietors or otherwise self-employed individuals may not be eligible for income-based subsidies, an alternative model would be to allow sole-proprietors to choose between the SHOP and the Exchange based on which option presents the best value coverage to the individual. Such a scenario, though, could increase the risk for adverse selection by permitting the distribution of the sole-proprietor population among the SHOP and Exchange based on factors that may correspond to health risk.

Recommendation: The final rule should clarify that sole proprietors or otherwise self-employed individuals are eligible for coverage through the individual Exchange.

c. Participating in multiple SHOPs
We support the requirement that SHOPs must offer employers with multiple worksites the opportunity to provide coverage for employees via the SHOP in which the employee's worksite

is located. Employers with multiple worksites within a state or across two or more states may have employees whose health care service areas may be vastly different. This provision prevents employees who do not work at the primary worksite from being limited to coverage options that do not include in-network providers in convenient locations.

In instances when an employer may participate in more than one SHOP to provide coverage to multiple work sites, the affected two or more SHOPs should be required to ensure coordination and information sharing necessary to provide all required functions to the employer and each employee. Further, the final rule should clarify how employer groups can still use premium calculations that mitigate the effects of age-rating, as described in our comments for section §155.705 (b)(2) and (b)(3), in instances where workers obtain coverage through more than one Exchange.

Recommendation: The final rule should clarify that coordination and information sharing must occur between SHOPs if small employers provide coverage through multiple SHOPs based on different employee worksites. The rule should also describe how employers can use composite premium rating (mitigating the effects of age) in situations where workers from the same employer obtain coverage through multiple SHOPs.

d. Continuing eligibility

We strongly support the requirement that SHOPs must continue to deem an employer as qualified even in instances where its number of employees has grown to exceed the definition of a small employer for the purposes of the SHOP until the employer either leaves the SHOP or becomes ineligible for other reasons.

§155.715- Eligibility determination process for SHOP

a. General requirement

We support the preamble's statement that self-attestation of employer workforce size, offer of employee coverage, and location of at least one employee worksite in the SHOP's service area is a sufficient method of verification for SHOP eligibility. The preamble states that information for determining employer eligibility should be "limited to the minimum information needed." We recommend that this language be included in section 155.715(a) of the final rule text so that SHOPs are required to only use the minimum information needed to "determine that the employer or individual who requests coverage is eligible…" This will decrease the application burdens placed on small employers.

Recommendation: The final rule should state that only the "minimum information needed" for SHOP eligibility determinations should be collected during the eligibility determination process.

b. Applications

We support the requirement that SHOPs use only two application forms: one for employers and one for employees. This will ease the administrative burdens placed on employers and employees seeking SHOP coverage.

c. Verification of application

In the verification process, like in the application process, SHOPs should be required to request only the minimum information needed for verification, and this should be clarified in the final rule. We support the development of an appeals process referenced in the preamble for instances in which an application from an employer or employee is denied due to the inability of the SHOP to verify the information. This appeals process should include notice requirements for employers and employees of the denial and the opportunity and process to appeal. It should also address how employees will be covered during the appeals process and should hold workers harmless for errors made by employers. If a SHOP application is denied (either before or after an appeal), employees should be granted a special enrollment period for the individual market Exchange.

Recommendation: The final rule should clarify in section 155.715(c) that SHOPs may require only the minimum information needed for verification of applications. The final rule or future rules should specify the right of employers and employees to appeal denials of SHOP eligibility. Rules should implement an appeals process that includes notice requirements and holds employees harmless, granting them special enrollment into the individual Exchange if their application or their employer's application for SHOP coverage is denied.

d. Eligibility adjustment period

We strongly support the rule's inclusion of an "eligibility adjustment period" during which a SHOP must make a reasonable effort to obtain verification information from employers or employees if the SHOP has reason to doubt the information on their application. We support that this includes a notice requirement and a uniform 30-day period during which the employer or employee can prevent more documentation or otherwise resolve an inconsistency. We recommend that the final rule clarify, in this section or in Section 155.720, the time period in which the SHOP must respond to an employer or employee's application, whether it's an initial application or any additional information submitted during an eligibility adjustment period, and issue an eligibility determination. Further, the final rule should state that employers or employees who are not deemed eligible for SHOP coverage after an "eligibility adjustment period" must have appeal rights and receive a notice of those rights.

Recommendation: The final rule should clarify a standardized time period by which the SHOP must respond to an application for coverage or additional information submitted during an eligibility adjustment period and issue an eligibility determination to an employer or employee. The final rule should state that employers or employees who are not deemed eligible for SHOP coverage after an "eligibility adjustment period" must have appeal rights and receive a notice of those rights.

g. Notification of employer withdrawal from SHOP

We support the requirement that SHOPs must ensure that employees are provided advance notice of pending termination of coverage when an employer is ceasing coverage through the SHOP. We believe that such a requirement should also apply in any other circumstances in which an employee's coverage through the SHOP is terminated, including when an employer loses eligibility or otherwise no longer receives coverage via the SHOP. We also believe that, as considered in the preamble, SHOPs should require that any notice of termination provided to employees include information regarding other coverage options for which the employee and his or her family may be eligible, including but not limited to, Medicaid, CHIP, or the individual

Exchange (include eligibility for special enrollment periods), as well as any associated premium tax credit or cost-sharing subsidies. Further, the final rule should specify how far in advance employees must receive a notice that their SHOP coverage will be discontinued. Employees must have adequate notice of discontinuation so that they have ample time to enroll in other coverage without a period of uninsurance.

Recommendation: The final rule must require SHOP termination notices for employees to include information about other coverage options including Medicaid, CHIP, and the individual Exchange. In addition, a required time period for notice should be specified in the final rule.

§155.720- Enrollment of employees into QHPs under SHOP

We support the requirement that SHOPs process employee applications to the applicable issuers and facilitate the enrollment of qualified employees into QHPs. However, the rule should clarify the duties that the SHOP must complete in order to "facilitate enrollment" of employees into QHPs. The final rule should clarify the roles of the SHOP versus the roles of the QHP issuers in enrolling employees into coverage.

We also support the requirements of section 155.720(b) that SHOPs establish uniform enrollment timelines and processes for enrollment. It is critical that these timelines be standardized so that, as described in the preamble, they do not differ by issuer and cause employers confusion and restricted choice due to varying enrollment deadlines.

We support the requirement of section 155.720(e) that SHOPs be held accountable for employees receiving notices of their effective date of coverage in a QHP. The final rule should clarify, or at least provide examples, for how SHOPs can enforce this requirement on QHP issuers.

Recommendation: The final rule should clearly define the duties of the SHOP to facilitate employee enrollment into QHPs. The final rule should also provide detail on how SHOPs must enforce requirements that QHPs provide notices to employees of their effective coverage dates.

§155.725- Enrollment periods under SHOP

We support the requirement that the initial open enrollment period for SHOPs mirror those of the Exchanges, commencing on October 1, 2013, and that there is no end date for such a period to reflect the continuous open enrollment opportunities for qualified employers. Starting enrollment on October 1, 2013 is critical for giving both employers and employees ample time to learn about the SHOP Exchange and their options for coverage. We also strongly support the requirement that SHOPs ensure that enrollment transactions are sent to QHP issuers and that such issuers adhere to required effective dates for coverage.

We support the requirement that SHOPs permit an employer to apply for coverage at any point during the year on a rolling basis. This is standard practice in the small group market, and will likely continue to be so in the small group market outside of the SHOP. Mirroring the rolling enrollment permitted in the outside market in the SHOP Exchange is critical to preventing small

employers from seeking coverage in the outside market, instead of the Exchange, whenever they are ready to do so. However, rolling enrollment poses the potential for adverse selection, as certain employer groups may wait to enroll in the SHOP until health care needs make it more advantageous to do so. Therefore, HHS should require SHOPs to include in their Exchange Plan a plan to encourage maximum enrollment of qualified employers into the SHOP during the initial open enrollment period.

We support the requirements that in advance of the end of an employer's plan year, SHOPs must provide: notice to employers of a pending annual election period, a time period for the employer to select plan offerings and contributions for the subsequent plan year, and a time period for employees to select a QHP. Requiring a uniform, time-limited period during which employers may change their employee coverage contribution, the level of coverage provided, or other features of their plan offerings is important to ensuring that employees are given ample advance notice of changes and that there is consistency in the process for both employers and employees. The preamble considers giving employers 30-days advance notice that this election period is approaching. We recommend codification of this requirement, and would also strongly recommend that, in order to ensure adequate time for small employers (who often have few or no administrative staff) to select QHP offerings, the final rule require that SHOPs provide a standardized employer election period that is at least 30 days long. We also strongly support the requirement that SHOPs have a standardized annual open enrollment period for qualified employees prior to the completion of the employer's plan year. We recommend that section 155.725(e) be modified to read that the "SHOP must establish *a standardized* annual open enrollment period *of at least 30 days* for qualified employees…" to clarify that this period must be uniform for all carriers. Further, the final rule should require a 30-day advance notice to employees that their open enrollment period is approaching.

We also strongly support the requirement that SHOPs have a standardized annual open enrollment period for qualified employees prior to the completion of the employer's plan year. We recommend that section 155.725(e) be modified to read that the "SHOP must establish *a standardized* annual open enrollment period *of at least 30 days* for qualified employees…" to clarify that this period must be uniform for all carriers. Further, the final rule should require employers to provide a 30-day advance notice to employees that their open enrollment period is approaching. This notice should indicate if any of their employer's QHP offerings have changed from the previous plan year. We provide further recommendations on this in our comments for Section 157.205 of the next set of proposed Exchange rules.

We strongly support the requirement that SHOPs provide coverage to any new employees hired by a qualified employer outside of the initial or annual open enrollment period, and that SHOPs be able to make that coverage available on their first day of employment. However, we are unclear as to how this requirement relates to the provision in Title I of the ACA that permits group plans to impose waiting periods for coverage of new employees of no more than 90-days.

Section 155.725(h) includes the provision that an individual will not remain in the same QHP as the previous year if that "QHP is no longer available to the qualified employee." Section 155.715(g) discusses employee notice requirements for when an employer leaves the SHOP. We recommend that section 155.725(h) include a similar requirement that if a QHP intends to leave the SHOP, enrollees receive advance notice from the plan that their current coverage option may

no longer be available.

Recommendation: The final rule should require SHOPs to provide a standardized QHP selection period for employers that is at least 60 days long. It should also require SHOPs to provide a uniform employee open enrollment period of no less than 30 days. Both employers and employees should receive advance notice of approaching election periods. The rule should state that employees must receive advance notice if their employer's plan offerings have changed or if the QHP in which they are enrolled will no longer be offered through the SHOP for the following year.

§155.730- Application standards for SHOP

As described in the preamble, the SHOP is not required to use the same, single streamlined application as the Exchange in the individual market, since the SHOP is not responsible for determining eligibility for advanceable premium tax credits or cost-sharing reductions. The preamble also states that the SHOP is not required to determine eligibility for Medicaid or CHIP. However, we recommend that the rule require a role for the SHOP in providing information about these programs. Employees of small businesses may be eligible for Medicaid or CHIP and may have access to more affordable coverage through those programs. The SHOP website should include clearly visible information about how employees can be screened for Medicaid or CHIP, and should indicate that these programs may provide workers with more affordable coverage. Further, the SHOP Exchange should have easily accessible information regarding what makes employer-sponsored coverage deemed "unaffordable" for a worker, thereby allowing them to cross the "firewall" and obtain coverage, possibly with an income-based premium credit, in the individual Exchange.

We support the provision that the SHOP must use a single application to determine employer eligibility and collect necessary information for purchasing coverage. The rule includes among this information a list of qualified employees and their social security numbers. We ask HHS to consider whether requiring employee social security numbers meets the standard of asking for only the minimum information needed to conduct SHOP enrollment, or whether other information could be requested instead of a social security number. Individuals generally prefer to restrict the use of their social security number to as few entities as possible. Particularly since the SHOP application process may be done online and applications may be submitted by other individuals or organizations on behalf of an employer, employees may not want to submit their social security numbers due to privacy concerns. We recommend that HHS consider for the final rule whether alternative information can be collected instead of social security numbers.

We support the requirement that the SHOP must use a single application for eligibility determination, QHP selection, and enrollment for qualified employees. This requirement will make the application process simple for employees, who will become familiar with the application over time. We recommend that the SHOP application be as similar as possible to the individual market application (although the amount and type of information requested on the SHOP application may be different) so that information sharing across Exchanges is easy when people transition between group and individual coverage (and vice versa) and so that individuals become familiar and comfortable with all Exchange (SHOP and individual) applications.

We strongly support the requirement of section 155.730(f) that SHOP applications be accepted in the same manner as individual Exchange applications. Requiring SHOPs to accept applications from employers and employees online, by phone, by mail, and in person will best accommodate the varying needs of different employers and workers, helping to maximize SHOP participation.

Recommendation: Under the final rule the SHOP must be required to provide accessible information about Medicaid, CHIP, and coverage options for when employer coverage is deemed unaffordable for a worker. For the final rule HHS should consider whether the application process can be completed with alternative sources of information instead of requiring employees to submit social security numbers for SHOP enrollment.

Certification Standards for QHPs- §155.1000

c. General certification criteria

Section 155.1000(c)(2) codifies the statutory requirement that an Exchange must determine that making a health plan available is "in the interest of qualified individuals and qualified employers" in order to certify it as a QHP. As described in the preamble, the proposed rule gives Exchanges discretion on how to determine whether a plan meets this standard. We are concerned that the preamble states that this discretion includes the option to "certify all health plans as QHPs solely on the basis that such plans meet and agree to comply with the minimum certification requirements" outlined in subpart C of part 156 of the rule. Under the statute, an Exchange may certify a health plan as a qualified health plan if: 1) the health plan meets the minimum certification requirements for QHPs (ACA Section 1311(e)(1)(A)) and 2) the Exchange determines that making the health plan available is in the interests of qualified individuals and qualified employers (ACA Section 1311(e)(1)(B)). As reflected in the text of the rule, these standards are discretely listed in the statute, implying that *both* standards must be independently met in order for an Exchange to certify a given health plan. A plan could meet the minimum QHP requirements but still not be in the interest of qualified individuals and employers. Therefore, we disagree with the rule's interpretation that an Exchange could deem a plan to comply with the second requirement for certification—that a plan is in the interests of qualified individuals and employers—based only on its compliance with the first requirement of meeting minimum QHP certification requirements. This interpretation essentially nullifies the second requirement that an Exchange assess whether offering a given QHP is in the interest of qualified individuals and employers.

Therefore, we believe that the final rule must clarify what standards, beyond the minimum QHP certification requirements, an Exchange must consider when determining whether making a health plan available is in the interest of qualified individuals and qualified employers. For example, one of the most important factors regarding whether a health insurance product serves consumers well is whether its rates are reasonable and fair. Therefore, the final rule should require the Exchange to consider (as explicitly stated in Section 155.1020) whether a plan has a history of unjustified rate increases when determining whether offering it is in the interests of qualified individuals or employers. A plan that implements unjust rate increases cannot be considered in the interests of enrollees. Additionally, a plan with a history of unfairly denying claims or otherwise engaging in unethical conduct, such as deceptive marketing, should also be deemed as not serving the interests of enrollees. These examples demonstrate that even if a health plan meets the minimum QHP certification requirements, it may engage in practices that

clearly are not in the interests of qualified individuals or businesses. Therefore, the final rule should clarify that before certifying a health plan as a QHP, an Exchange must independently assess whether the plan costs, conduct of the issuer, or any other features of the health plan would prevent its availability in the Exchange from being in the interests of qualified individuals or businesses.

Further, neither the preamble nor the rule itself make it clear that, in order for an Exchange to be ACA compliant, the Exchange must have the discretionary ability to certify or not certify a plan based on a determination of whether offering the plan is in the interests of qualified individuals and qualified employers. There are currently bills pending in state legislatures that would require an Exchange to certify any qualified plan. Some pending bills also prohibit "active purchasing." Such provisions, if enacted, would conflict with §1311(e)(1)(B) of the ACA because they effectively eliminate an Exchange's ability to make a determination of whether a particular plan's participation in the Exchange is in the interests of enrollees. HHS should clarify that state statutory or regulatory provisions that eliminate the ability of Exchange leadership to make a determination that a health plan is or is not in the interests of enrollees are in conflict with the ACA.

Recommendation: The final rule should clarify that Exchanges must both certify that a health plan meets the minimum QHP certification standards *and* independently determine that offering a plan is in the interests of qualified individuals and employers before certifying it as a QHP. The rule must also clarify that state statutory or regulatory provisions that take away the ability of Exchange leadership to make a determination that a health plan is or is not in the interests of Exchange enrollees violates the ACA.

Defining "premium price controls"

The rule proposes to codify §1311(e)(1)(B) of the ACA, which prohibits an Exchange from excluding a plan through the imposition of "premium price controls." The rule does not, however, propose any definition of "premium price controls" and the term is not defined elsewhere in federal law or regulations.

However, a common understanding of the term "price controls" means the "establishment and maintenance of maximum price levels for basic goods and services by a government."[13] This would suggest that Congress intended to prohibit Exchanges from establishing and maintaining a set of maximum premium prices for QHPs. At the same time, the setting and maintaining of price controls does *not* connote negotiations over price, nor does it include a selective contracting process in which the lowest bidder wins.

Congress in fact requires Exchanges to take premiums and any premium increases into account in determining a plan's eligibility to participate in the Exchange.[14] And the preamble to the rule correctly notes that Exchanges may choose to negotiate with issuers on a case-by-case basis or to establish a competitive bidding process for selecting QHPs. The preamble also notes that an Exchange may wish to set additional selection criteria for QHPs beyond the criteria in the ACA, including examples such as the "reasonableness of the estimated costs supporting the calculation of the health plan's premium and cost-sharing levels."

The final rule should include a clear definition of "premium price controls" that limits the term to

mean *only* the setting, publishing, and maintaining of maximum premium prices for QHPs, and nothing more.

Recommendation: The final rule should narrowly define "premium price controls" to include only provisions that would explicitly require QHPs to maintain a particular price for a particular product. It should clarify that "premium price controls" do *not* include an Exchange's efforts to engage in selective or performance-based contracting, encourage provider payment reform, or negotiate premium prices with QHPs.

Certification process for QHPs- §155.1010

b. Exemption from certification process

We are concerned about the implications of §155.1010(b) of the proposed rule, which requires each Exchange to accept multi-State plans (MSPs) as QHPs without applying a certification process to such plans. While we appreciate that this rule is an interpretation of §1334(d) of the ACA, it could significantly undermine an Exchange's ability to meet the needs of qualified individuals and employers in each state. In order to effectively serve enrollees and provide a range of attractive, affordable insurance products, many Exchanges will want to require QHPs to meet additional requirements beyond the minimum requirements delineated in §1311 of the ACA. These could include efforts to encourage greater value through performance-based contracting, benefit standardization, and other active purchasing strategies. If MSPs are not required to meet all of the Exchanges' certification requirements, they could undermine Exchange efforts to serve consumers well and could place other QHPs at a competitive disadvantage.

We recognize, however, that it is the U.S. Office of Personnel Management (OPM) that is charged with certifying MSPs. We urge HHS to work with officials at OPM to ensure that MSPs meet not only the minimum federal requirements for exchange certification, but also any additional requirements that an Exchange may establish.

Recommendation: HHS should work with the U.S. Office of Personnel Management to ensure that MSPs must meet *all* requirements of Exchanges, including those that are beyond the minimum requirements of the ACA.

c. Completion date

We support the provision of the rule requiring an Exchange to complete QHP certification prior to the open enrollment period. This is critical for consumer choice and ease in obtaining coverage.

d. Ongoing compliance

We support the requirement that an Exchange must monitor QHP issuers for ongoing compliance with the certification requirements. However, we are concerned that the rule does not explain what an Exchange has to do to meet this requirement. We recommend that the final rule provide clarification on what processes qualify as monitoring for this purpose. Under this section, Exchanges should be required to investigate consumer complaints or information provided by a consumer assistance program/ ombudsman or other entity indicating that a plan may not be complying with the minimum certification requirements. This investigation should take place

within a limited amount of time, such as 30 days after information of potential noncompliance is received. Further, more consistent formal monitoring should be required under the final rule in order to truly ensure that plans demonstrate ongoing compliance.

In addition, we are concerned that the rule gives complete flexibility to Exchanges regarding how to respond to a finding that a QHP has ceased compliance with the certification standards. The statute requires all Exchange plans to have effective certifications of compliance with QHP criteria (ACA Section 1301). Therefore, we believe that the preamble language stating that, "If the QHP issuers or their QHPs cease to demonstrate ongoing compliance, the Exchange may be inclined to seek actions against the issuer or try to remedy the situation," is too weak to meet the statutory requirement that all plans in an Exchange consistently meet QHP certification standards. We believe that Exchanges must be required not only to perform ongoing monitoring of QHP compliance with the certification standards, but to ensure that any QHPs that are not in compliance with the standards remedy their problems within a limited period of time. Plans that are not in compliance should be subject to a system of sanctions, such as that used in Medicaid managed care (described below). Exchanges must be required to remove plans' QHP certification and cease to include the plans in the Exchange if they do not remedy their problems within a limited period of time. The process for plan decertification (Section 155.1080), including the provision of a special enrollment period for a decertified plan's enrollees, must take place at this time.

HHS should consider strategies similar to those used in state Medicaid managed care programs for monitoring compliance and for sanctioning plans when there are issues of non-compliance. For example, 42 CFR 438.700 explains that Medicaid managed care plans can be sanctioned for failing substantially to provide required covered services, false marketing, or misrepresenting information to CMS or to a state. Sanctions can range from civil penalties to suspending new enrollment to allowing current enrollees to immediately terminate coverage with the plan and enroll elsewhere. HHS should consider whether a similar system of sanctions would be appropriate in this rule.

We are concerned that the rule fails to clarify how HHS will ensure that Exchanges are monitoring QHP issuers for ongoing compliance in accordance with section 155.1000(d). Whether in the final rule or in future regulations on oversight, HHS should clarify how it will enforce this requirement and what it will do to ensure that only QHPs with effective certification are sold in Exchanges if Exchanges do not abide by the requirement to monitor QHPs for ongoing compliance.

Recommendation: The final rule should define the processes that Exchanges must complete in order to comply with the requirement to perform ongoing monitoring of plan compliance with QHP certification requirements, including processes to respond to consumer or other complaints of plan non-compliance within a limited amount of time. Additionally, the final rule must specify that if a plan is found to be out of compliance with certification standards, it should be subject to a system of sanctions, and the Exchange must decertify the plan if the plan does not come into compliance within a limited amount of time. The final rule should also describe how HHS will enforce Exchange compliance with section 155.1010(d).

§155.1020- QHP issuer rate and benefit information

a. Receipt and posting of rate increase justification

This provision states that the Exchange should receive "a justification" for a QHP rate increase and ensure that the QHP issuer prominently posts the justification on its website. The preamble considers allowing an Exchange to develop a "less burdensome rate justification" process to satisfy section 1311(e)(2) of the ACA where section 2794 of the Public Health Service Act (rate review for plans that meet the federal standard of "subject to review") does not apply. We oppose this proposal and believe that in order to ensure that plans in the Exchange are in the "interests of qualified individuals and qualified employers" (in accordance with section 1311(e)(1)(B) of the Affordable Care Act), all rate increases for QHPs must be fully justified and considered by the Exchange and justifications must be transparent to consumers. For plans that are subject to review under section 2794 of the Public Health Service Act, the Exchange should receive all documentation related to the rate increase, whether or not it was found to be unreasonable. While the Exchange should not duplicate this review or any other rate review process performed by state regulators, it will be necessary for the Exchange to have complete documentation of rate increases, since the Exchange is obligated under the ACA to independently consider plan rate increases for the QHP certification process. For all QHPs with rate increases, the Exchange should post a link to their rate justifications on its website so that they are transparent to consumers shopping for coverage.

Recommendation: The final rule should require complete justification of all QHP rate increases and state that links to justifications for QHP rate increases must be available on the Exchange website wherever the QHP premium and cost-sharing information is quoted. Further, the final rule should amend §155.1020(a) to indicate that the Exchange must receive all documentation related to a rate that underwent review by regulators, whether or not it was found to be unreasonable.

When a rate has been found to be unreasonable, that fact should be prominently displayed on the Exchange website in every place where the plan's premium and cost-sharing information is quoted. An unreasonable rate determination should be indicated with a bolded statement in the same font size used to display the premium that reads, "This premium rate has been determined to be unreasonable." The rate justification process will yield valuable information that consumers should be able to easily access. It would be contrary to the intent of the statute, which puts a primacy on transparency, to fail to indicate that a rate has been found unreasonable, to force consumers to go to a separate website to find this information, or to hide the rate review result in vague language. To ensure that consumers are fully informed that an extensive professional review process has found a rate increase to be unjustified, a "pop-up" warning box should appear when consumers are asked to confirm their plan selection and payment obligations, similar to the messages that appear in the HHS Plan Finder. To close this box, a consumer should have to affirmatively indicate that they understand that the premium rate for the plan they are selecting has been determined to be unreasonable.

Recommendation: The Exchange website should prominently display the determination that a plan's rate has been found unreasonable. This should also be added to the requirements of §155.205. Consumers should be able to click on a link to access a plain language description of the final rate review determination and how it was conducted and

should have to acknowledge a "pop-up" warning box before purchasing a plan with an unjustified rate increase.

b. Rate increase consideration

As in the statute, the regulation states that the Exchange should consider rate increases in determining whether to certify a plan as a QHP. This "consideration" should be transparent to the public in some way. For instance, an Exchange could conduct a hearing or establish a public comment period to obtain input on whether to certify or recertify a plan with a proposed rate increase.

The final rule should also define the criteria that an Exchange must evaluate in considering rate increases for the QHP certification process. Although the preamble states that Exchanges have an ongoing obligation to consider rate increase justifications in the QHP certification process, the proposed rule provides no guidance as to how Exchanges comply with this requirement or what action HHS will take if an Exchange does not comply.

The final rule should therefore outline the processes that Exchanges must use to consider a plan's proposed and historical rate increases in accordance with section 1311(e)(2) of the Affordable Care Act. For example, the final rule could require Exchanges to assess plans based on the number of times a plan's rate increase was determined unreasonable under section 2794 of the Affordable Care Act. The final rule should outline how HHS will monitor Exchange compliance with the rate consideration process. Additionally, Exchanges should be required to submit a detailed explanation of how they will comply with the requirements to consider rate increases in QHP certification and recertification in the Exchange Plans that they submit to HHS for approval.

We agree that Exchanges should not duplicate rate review processes already conducted by regulators. However, the final rule should make clear that even if an Exchange leverages an existing rate review process, the Exchange must still have an independent process to consider any rate justification information it receives from regulators in accordance with section 1311(e)(2) of the Affordable Care Act.

Recommendation: The final rule should clarify that even if an Exchange leverages an existing rate review process, it must independently consider plan rate increases before certifying the plan as a QHP. The consideration of rate increases should occur in the public domain and should provide an opportunity for consumers to comment on whether a plan should receive QHP certification or recertification based on rate increases. The final rule should outline the process that states must use to consider rate increases in QHP certification and recertification and Exchanges should be required to describe their process for considering rate increases in their Exchange Plans to HHS. The final rule should describe how HHS will enforce the requirement that Exchanges consider rate increases in the QHP certification process.

c. Benefit and rate information

We support the requirement of §155.1020(c) that QHPs submit rate, benefit, and cost-sharing information to the Exchange at least annually. Detailed information about plan benefits and rates must be collected to determine plan compliance with QHP standards, including, but not limited

to, adherence to the essential health benefits and actuarial value requirements under section 1302 of the Affordable Care Act and adherence to the requirement that QHPs do not employ benefit designs that have the effect of discouraging enrollment by individuals with significant health needs under section 1311(c)(1)(A) of the Affordable Care Act. To ensure that adequate information is collected, "(2) Covered benefits" in the final rule should be expanded to include specific information about amount, duration, and scope of benefits. In addition, such information should highlight changes to benefits from the previous plan year.

The final rule should specify by when each year rate, benefit, and cost-sharing information must be provided. The submission deadline for QHPs should be prior to the deadline for plan certification and/or recertification. The preamble of the proposed rules states that HHS will provide the form and manner for the submission of rate, benefit, and cost-sharing information. The final rule should indicate when such information will be released and in what form HHS will provide it.

Recommendation: The final rule should include more specificity regarding the required benefit and rate information to ensure that the Exchange has specific information about the amount, duration, and scope of benefits covered, as well as changes to benefits. It should also specify by when each year rate, benefit, and cost-sharing information must be provided.

§155.1040- Transparency in Coverage

The regulation places complementary requirements on Exchanges and QHP issuers regarding the disclosure of key information in plain language to Exchanges, HHS, State Insurance Commissioners, and the public. We strongly support the codification of the important transparency protections in the proposed rule. The required information will help consumers pick coverage that best meets their needs and understand their coverage and their rights. It will also help regulatory bodies monitor compliance with Exchange rules and requirements, as well as state and federal laws and regulations.

These same requirements will also apply to all group health plans and health insurance issuers in the individual and group markets under §2715A of the PHSA, and we encourage HHS, in coordination with DOL and Treasury, to promulgate clear federal minimum standards that build on the proposed rule. Such standards should include definitions and methodologies for reporting the required elements, as well as timelines and penalties for non-compliance. Additional federal guidance will provide clarity for health insurance issuers and minimize the burden on issuers operating in multiple markets and states. Standardized reporting requirements will also reduce consumer confusion and provide consumers with confidence that they are looking at comparable information across plans and policies.

As the agencies further refine the transparency in coverage reporting requirements, we urge you to create a process that meets the information needs of all the intended recipients without being overly burdensome. HHS should recognize that this information will be used for a range of purposes: to help consumers distinguish between QHPs as they shop for coverage and understand the terms of the coverage that they already have, to help Exchanges determine if a health plan is in the interest of the qualified individuals, and to aid State Insurance Commissioners and HHS in

their oversight and enforcement activities. The public will also have access to information reported to regulators, so consumer advocates and other interested parties will be able to provide informed input on oversight and policy. Therefore, one-size-fits-all reporting requirements may not be appropriate. In particular, HHS should consider that plain language information will be essential for consumers to compare QHPs, while regulatory bodies may require more granular data to monitor compliance with the ACA and other laws. It is imperative that HHS reconcile these needs effectively and efficiently in future regulations and guidance.

a. General requirement

The proposed rule requires Exchanges to collect information relating to transparency from QHP issuers. As discussed later in the rule, QHP issuers must submit this information to Exchanges, HHS, and State Insurance Commissioners in an accurate and timely manner and also make the information available to the public. We strongly support the codification of this statutory requirement, but we would encourage HHS to provide additional guidance on how this should be operationalized.

First, HHS should establish a clear timeframe for how often Exchanges will collect this information. We recommend that Exchanges collect this information annually, aligned to the extent feasible with the timing of certification and recertification of QHPs. HHS should also create a process for how to handle late or inaccurate submissions, and ultimately assess a penalty on non-compliant issuers for each plan or policy not in compliance. At a minimum, Exchanges should have the authority to enforce this requirement with respect to QHPs, although HHS should also consider what role the other intended recipients of this information have in enforcement.

Second, HHS should consider whether Exchanges can play a role as an aggregator and disseminator of the information for QHPs. Could QHPs submit this information through a single portal offered by the Exchange or HHS that then directs it to the other entities? In §155.205(b)(1), HHS begins to move in this direction, requiring that the transparency of coverage measures for QHPs be presented on an Exchange's website. Consumers will benefit from having this information available from all plans in one place. However, even when Exchanges or HHS are making transparency of coverage information available on a public website, issuers must be required to provide transparency information directly to a consumer in a timely manner upon request, as discussed in greater detail §156.220(c).

Third, HHS should consider how information should best be categorized and displayed and should clarify that states may require additional parameters. For example, QHPs must provide data on the number of claims denied. Some states, such as Maryland, now require plans to report on the number of claims in various service categories that they deny, the number that are appealed internally or externally, and the outcome of those appeals. States may also separate data on denials that are due to incomplete submissions from data on denials that are due to disagreements about medical necessity. This makes the data much more useful for program oversight.

Recommendations: HHS should require Exchanges to collect transparency information annually from QHPs, either before or when a QHP seeks certification or recertification. HHS should also define an enforcement process. In addition, HHS should consider utilizing

Exchanges as an aggregator/ disseminator of transparency information to minimize burden and increase efficiency of the reporting process. States and HHS should set further parameters on how QHPs will report the required information.

b. Use of plain language

The proposed rule requires Exchanges to determine whether the transparency in coverage measures are provided in plain language. According to the preamble, Exchanges will need to ensure that QHP issuers' use of plan language is consistent with forthcoming guidance on best practices of plain language writing from HHS and DOL as well as the definition provided in §155.20 ("Plain language means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing").

We strongly support the codification of this requirement and urge HHS to further detail what steps an Exchange should take if it determines that the information has not been submitted in plain language. An enforcement process should include a reasonable timeframe for corrections or amendments and ultimately, a penalty for non-compliance within a determined timeframe.

We look forward to working with HHS and DOL to develop the guidance on best practices for plain language writing. Information should be provided using clear, consistent, and concise language written at the lowest reasonable education level, and steps should be taken to make it understandable by individuals with low literacy and numeracy levels. HHS and DOL should also take into consideration additional barriers to understanding including but not limited to, limited English proficiency (LEP); cultural differences; sensory, intellectual, and other disabilities; low health literacy levels; and low levels of familiarity with insurance and financial terms and concepts. HHS and DOL should work with NAIC to identify any lessons learned from its work to develop recommendations on the summary of benefits and coverage documents. In addition, the agencies should engage individuals and organizations with expertise in plain language writing, as well as language and disability access. HHS and the Exchanges should also regularly solicit feedback from consumers about the usability of the information provided and make adjustments to the best practices guidance as appropriate.

Recommendations: HHS should establish an enforcement process for the plain language requirement. HHS and DOL should work with individuals and organizations with expertise in plain language writing and language and disability access, as well as use lessons learned from NAIC's work developing recommendations for a template summary of benefit and coverage document.

c. Transparency of cost-sharing information

The proposed rule requires Exchanges to monitor whether a QHP issuer has made the amount of enrollee cost-sharing under the individual policy with respect to a specific item or service provided by a participating provider available in a timely manner upon the request of an individual.

In response to §156.220(d), we discuss requirements that QHPs must meet when providing this information, as well as information pertaining to all transparency in coverage measures outlined under §156.220(a), upon request. HHS should provide guidance on how an Exchange will

monitor compliance with this requirement. In particular, HHS should allow Exchanges to institute financial penalties for non-compliance.

Recommendation: HHS should provide guidance on how an Exchange will monitor compliance with this requirement. In particular, Exchanges should clearly state on the Exchange website that consumers can request this information from QHPs and provide appropriate contact information. In addition, HHS should allow Exchanges to institute financial penalties for non-compliance.

§155.1045- Accreditation timeline

Families USA believes that health plan accreditation provides important protection to consumers and employers. Therefore, we support both the statutory requirement that QHP issuers be accredited and the requirement in the proposed rule that there be a consistent deadline for accreditation with respect to each QHP issuer's initial participation in the Exchange. However, since we view accreditation as essential, we strongly urge HHS to establish a federal accreditation timeline, rather than rely on states to individually establish this process. A federal accreditation timeline would minimize burden on all parties, including QHP issuers that may operate in multiple states and therefore could find it challenging to comply with different accreditation timelines.

For the federal timeline, we recommend that the final rule adopt a maximum grace period of one year after certification during which a QHP issuer must become accredited if it is not already. We believe that a one-year timeline is sufficient to accommodate the length of the accreditation process. If a QHP issuer cannot complete the accreditation process within a year, it should be required to document extenuating circumstances causing the delay and Exchanges should have limited authority to grant extensions to the grace period. HHS should also consider limiting the accreditation grace period to new issuers only.

Finally, the final rule should articulate the actions that an Exchange must take if a QHP doesn't meet the requirements of the accreditation timeline. Namely, such a plan should be decertified if it doesn't meet the deadline and doesn't qualify for an extension. In this instance, a special enrollment period for the decertified plan's enrollees, must take place. HHS should clarify how it will monitor Exchanges to ensure that they are fulfilling their duties under Section 155.1045 and adequately overseeing plans to ensure that they meet accreditation deadlines.

Recommendation: The final rule should establish a federal, one-year timeline under which QHP issuers must become accredited if they aren't already at the time of certification. It should also outline the actions that an Exchange must take if a QHP doesn't meet the deadline and the actions that HHS will take to monitor Exchange compliance with this section.

§155.1050- Establishment of Exchange network adequacy standards

As stated in the preamble, Section 1311 of the ACA requires HHS to establish network adequacy requirements for health insurance issuers seeking QHP certification. However, the proposed rule allows states to establish their own QHP network adequacy standards. We are concerned that this will lead to great variation in consumers' access to providers nationwide and insufficient standards of network adequacy in some states. The preamble to the proposed rule solicits

comment on additional minimum standards for Exchanges to use in evaluating whether a provider network provides sufficient access to care. Families USA recommends that HHS establish minimum federal standards for QHP network adequacy. Such standards can be broad enough to ensure that they are appropriate for each state's needs.

Network adequacy requirements

We believe that the NAIC's Managed Care Plan Network Adequacy Model Act provides an appropriate and balanced framework for a national network adequacy requirement. In addition, private accreditation programs can serve as an added oversight and enforcement mechanism, provided that accreditation requirements for availability of practitioners, access to services, and other related elements are aligned with the national network adequacy requirements that HHS should include in the final rule. This approach has the advantage of building on existing federal and state network adequacy regulations and guidance and private accreditation standards. Within the framework of the NAIC's Managed Care Plan Network Adequacy Model Act requirements, states would still have flexibility to ensure that they meet the geographic, demographic, and other needs of their residents. For example, rural states may wish to allow licensed and credentialed telemedicine providers be included as network providers.

We note that the law requires all QHPs—both managed care plans and health indemnity plans—to meet the minimum national network adequacy standards. Health indemnity plans are defined by the NAIC Model Act as "a health benefit plan that is not a managed care plan," and therefore they are not included in the Managed Care Network Adequacy Model Act. However, health indemnity plans that seek to be QHPs must be required to meet the same minimum national network adequacy requirements as QHPs that are managed care plans.

Recommendations: HHS should adopt the NAIC Managed Care Plan Network Adequacy Model Act as the minimum national network adequacy requirements for QHP certification and add provisions to require QHPs that are health indemnity plans to demonstrate that they meet the same network adequacy standards.

Network Adequacy minimum qualitative or quantitative standards

The proposed rule solicits comments on additional minimum qualitative or quantitative standards for the Exchange to use in evaluating whether QHP provider networks provide sufficient access to care. As noted above, we support building on existing federal and state network adequacy regulations and guidance, the NAIC Model Act, and private accreditation standards in defining the national minimum standards. Medicare recently issued its Contract Year 2012 Medicare Advantage Health Services Delivery Guidance for applicants who apply to offer Coordinated Care Plans (CCP) and network Private Fee for Service (PFFS) plans. These plans must "demonstrate that they have an adequate contracted provider network that is sufficient to provide access to covered services," as required by 42 CFS 422.112(a)(1). This guidance establishes criteria for network adequacy and uses a geo access analysis to determine whether an adequate network is available. It also has five geographic categories: large metro, metropolitan, micro-metropolitan, rural and Counties with Extreme Access Considerations (CEAC).

The Medicare Advantage approach and criteria for determining network adequacy could be

valuable and effective as the minimum qualitative and quantitative standards to assure sufficient access to care for all enrollees, including those in medically underserved areas.

In addition, determination of network adequacy should take into account whether a QHP has sufficient providers to meet the specific needs of the population to be served. This includes providers that can treat people with disabilities appropriately and that can deliver care in a culturally competent manner and serve people with limited English proficiency.

Recommendation: HHS should adopt the Medicare Advantage approach and criteria for determining network adequacy as the minimum qualitative or quantitative standards for an Exchange to use in determining that a QHP has sufficient numbers and types of providers to provide access to covered services. The final rule should also require a plan to have sufficient providers to serve populations with disabilities and LEP in order to meet network adequacy standards.

Additional requirements regarding access and availability of providers

The proposed rule also seeks comment on a potential additional requirement that the Exchange establish specific standards requiring QHP to maintain the following: (1) sufficient numbers and types of providers to assure that services are accessible without unreasonable delay; (2) arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients; (3) an ongoing monitoring process to ensure sufficiency of the network for enrollees; and (4) a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner.

We support this additional requirement as the baseline for establishing specific standards related to assuring access and availability of providers. As noted in the proposed rule, these standards are largely based on the NAIC Managed Care Plan Network Adequacy Model Act, which has already been adopted by about 20 states, and are similar to national accreditation entities health plan and health network adequacy standards, thus reducing the administrative burden on complying with this additional requirement.

A formalized process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner would be of significant value to enrollees. Consumers may struggle to get needed care at an affordable cost if providers in their area are not willing to participate in a health plan network or accept the health plan reimbursement and the enrollee is required to pay the full cost of the services and submit the bill for payment to the health plan. Additionally, in a hospital setting, enrollees may find that some providers are in their network, but others are not. In this case, the enrollee may have little or no control over whether providers involved in the enrollee's treatment are in the plan network. The end result is that enrollees incur significant unplanned and unaffordable costs. A requirement that enrollees in this situation only have to pay in-network costs is therefore critical. Further, the final rule should clarify that the standards for determining whether a network provider is "accessible" include appointment availability, proximity, transportation availability for the consumer, and other factors that influence a patient's ability to

reach a provider.

Recommendation: The final rule should include the additional requirements proposed in the preamble under which QHP issuers must maintain: (1) sufficient numbers and types of providers to assure that services are accessible without unreasonable delay; (2) arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients; (3) an ongoing monitoring process to ensure sufficiency of the network for enrollees; and (4) a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner as part of minimum national network adequacy requirements for QHPs.

Scope of Network Standards

The preamble seeks comment on additional standards that would require Exchanges to "ensure that QHPs' provider networks provide sufficient access to care for all enrollees, including those in medically underserved areas." The proposed standard would require a provider network to ensure "reasonable access to care for all enrollees enrolled through the Exchange, regardless of an enrollee's medical condition." We support the adoption of this standard, which will ensure that consumers in isolated geographic areas, regardless of health status, are able to access needed care. The preamble suggests mechanisms of meeting these standards, such as using telemedicine and broadly defining providers (including the use of nurse practitioners for primary care delivery). Families USA supports these approaches, but recognizes that state laws regarding provider licensing may impede the ability of telemedicine and broadly defined providers to adequately serve consumers. HHS and states should consider mechanisms to remove barriers to broadly defining providers so that consumers in underserved areas can obtain necessary care. Further, under the requirement that QHPs provide sufficient access to care for all enrollees, QHPs should be required to address the cultural needs of their enrollees, such as by providing access to multilingual practitioners.

Recommendation: The final rule should include the proposed requirement that Exchanges must ensure that "QHPs' provider networks provide sufficient access to care for all enrollees, including those in medically underserved areas."

Enforcement

The final rule should articulate the actions that an Exchange must take if a QHP doesn't meet the requirements for network adequacy. The Exchange must ensure that any QHPs that are not in compliance with the standards remedy their problems within a limited period of time. Plans that are not in compliance should be subject to a system of sanctions, such as that used in Medicaid managed care or that used in Medicare Advantage in which a plan may not take new enrollees while working to come into compliance. Exchanges must be required to remove plans' QHP certification and cease to include the plans in the Exchange if they do not remedy their problems within a limited period of time. The process for plan decertification (Section 155.1080), including the provision of a special enrollment period for a decertified plan's enrollees, must take place at this time. HHS should clarify how it will monitor Exchanges to ensure that they are fulfilling their duties under Section 155.1050 and adequately overseeing plans to ensure that they

meet network adequacy requirements. HHS and Exchanges should consider employing "secret shopper" programs to determine whether listed providers are truly available to consumers in accordance with network adequacy standards.

Recommendation: The final rule should articulate the duties of Exchanges in monitoring QHP compliance with network adequacy standards and the duties of HHS in ensuring Exchange compliance with Section 155.1050.

§155.1055- Service area of a QHP

The service areas of an Exchange should be consistent with those in a state's insurance markets outside the Exchange. If they are not, the Exchange plans may be at risk of adverse selection, because their competitors in the outside markets may have greater ability to pick and choose the areas where they will offer their products, potentially in ways that avoid sicker, high-cost enrollees.

One way for Exchanges to achieve consistency in QHP service areas is to establish them based on the geographic rating areas that states must establish under Section 2701(a)(1)(A) of the Public Health Service Act. As the preamble to the proposed rule notes, these rating areas will apply inside and outside an insurance Exchange. Depending on how the rating areas are ultimately established, it is likely to be appropriate in many cases for an Exchange's QHP service areas to match the state's rating areas.

An Exchange may find that not all plans will be able to fit pre-determined service areas, in particular if they match the geographic rating areas and the rating areas are large. For example, a local or community-based plan may serve only part of a county or metropolitan area. Rather than requiring plans to drastically change their service area, we support allowing the Exchange to grant exceptions to the service area boundaries, but only in cases when such an exception meets the conditions of being necessary, non-discriminatory, and in the best interest of qualified individuals or employers.

Families USA supports the requirement that a QHP service area cover at least a county (or a group of counties defined by the Exchange), with an exception for when the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of qualified individuals and employers. The preamble refers to examples provided in Medicare Advantage standards for determining "whether serving a partial county would fall under the necessary or nondiscriminatory standards." We recommend the inclusion of such examples in this final rule, as well, so that Exchanges better understand the service area standards they are to use.

We are concerned, however, that particularly when a QHP's service area is small, enrollees may face high charges when they receive out-of-network emergency care outside of their QHP's service area from non-participating providers. While the Affordable Care Act eases the financial burden of emergency care somewhat by setting a floor on plan payments for out-of-network care, it does not require that nonparticipating providers accept those payment rates. We recommend that states provide for statewide agreements, or agreements between QHPs, that hold enrollees harmless for any emergency charges beyond their own plan's cost-sharing amount.

We support the requirement that QHP service areas be established without regard to racial,

ethnic, language, and health status-related factors, as well as other factors that exclude specific high utilizing, high cost, or medically underserved populations. A specific factor that can be used to exclude high-utilizing populations is economic status. The final rule should list "economic factors" as another specifically prohibited consideration in the determination of service areas. Further, in the final rule or in future guidance, HHS should describe how it will monitor QHP service areas to be sure that these standards are met.

Recommendation: HHS should encourage Exchanges to adopt service areas that mirror those in the outside market, such as through the use of geographic rating areas as service areas. The final rule should include examples of "whether serving a partial county would fall under the necessary or nondiscriminatory standards," along with examples of when it would be in the best interest of qualified individuals and employers. HHS should require Exchanges to ensure that enrollees will not face higher charges for emergency services that are furnished outside of their QHP's service area. The final rule should add "economic factors" as a prohibited consideration in the establishment of a QHP service area. Finally, HHS should clarify how it will monitor QHP service areas to ensure they meet the standards outlined in the rule.

§155.1065- Stand-alone dental plans

This section takes on the difficult task of accommodating several provisions of the statute that are not perfectly aligned:

- Section 1302(b)(1), which sets out the categories of essential health benefits, requires that QHPs provide pediatric oral health care. However, there is no requirement that QHPs provide oral health care for adults.

- Section 1311(d)(2)(B)(ii) requires that Exchanges allow issuers of stand-alone dental benefits to offer their plans in the Exchange either separately or in conjunction with a QHP as long as the plan provides pediatric dental benefits as required under section 1302.

- Section 1302(b)(4)(F) states that if a stand-alone dental plan is offered in the Exchange, another plan offered through the Exchange "shall not fail to be treated" as a QHP solely because the plan doesn't offer a pediatric dental benefit.

- Section 36B(b)(3)(E) of the Internal Revenue Code states that the portion of the premiums payable to a stand-alone dental plan allocable to the pediatric benefit should be treated as a premium for the QHP.

As interpreted in the proposed rule, we are concerned that individuals and families seeking coverage through Exchanges will not be able to access the pediatric dental essential benefit due to a lack of choice and a lack of affordability. While we assume that many QHP issuers will offer pediatric dental coverage as a part of the QHP benefits, this may not be the case in all Exchanges. If pediatric benefits are only available in the Exchange through a stand-alone family plan, families will only be able to obtain the required pediatric benefits if they purchase a plan that also

covers adult dental care. Solely offering a family dental benefit, either as a part of a QHP or as a stand-alone dental plan, would make it much more expensive for consumers to obtain pediatric dental coverage because premium tax credits could not be used towards the adult dental benefit, as adult dental coverage is not included in the essential benefits package. To ensure the intent of the statute to provide all children with essential oral health care is carried out, we recommend that the final rule requires each Exchange to offer at least one option at every coverage level that allows families to obtain pediatric dental benefits without having to purchase a dental plan for adults in the family. This could be accomplished through requiring a child-only dental benefit, either through a QHP or as a stand-alone plan, at every coverage level**.** This will ensure that pediatric dental coverage is financially accessible for low- and middle-income families, even when a family dental benefit is too expensive. If coverage cannot be offered at every coverage level, at a minimum it is essential that the Exchange offers at least one child-only dental benefit, either as a part of a QHP or as a stand-alone plan, at the silver level, since premium tax credits are calculated for coverage at this level.

We also acknowledge the concern voiced in the preamble of the proposed rule regarding the allocation of premium tax credits for dental benefits. We understand that it may be difficult to allocate advanced payments of premium tax credits and calculate the actuarial value when stand-alone dental plans segment the essential benefits. However, we believe it is essential and required by the statute that pediatric dental coverage, whether offered through a QHP or as a stand-alone plan, can be paid for with a premium tax credit. Families must not be required to spend more money to obtain pediatric dental benefits for their children because pediatric dental coverage is a part of the essential benefits package. It would make it easier to meet this requirement if the pediatric dental benefit is offered as a part of the QHP benefit package, rather than as a stand-alone plan. We recommend that HHS encourage states to proactively pursue the availability of integrated child-only dental benefits during QHP certification to make it easier to allocate premium tax credits.

Recommendation: Each Exchange should offer at least one child-only dental benefit, either as a part of a QHP or as a stand-alone plan, at every coverage level in the Exchange. At a minimum, the final rule should require that each Exchange must offer at least one child-only dental benefit, either as a part of a QHP or as a stand-alone plan, at the silver level. In addition, consumers must be able to pay for the pediatric dental essential benefit with premium tax credits. We recommend that HHS encourage states to proactively pursue the availability of integrated child-only dental benefits during QHP certification to make it easier to allocate premium tax credits.

c. Certification standards

We also believe that it is crucial to require stand-alone dental plans to comply with adequate certification requirements and consumer protections. In the preamble of the proposed rule, HHS states: "We are considering interpreting this provision such that an Exchange may require issuers of stand-alone dental plans to comply with any QHP certification requirements and consumer protections that the Exchange determines to be relevant and necessary." We believe that there must be a Federal minimum of certification standards and consumer protections for the stand-alone dental plans, and we urge HHS to require stand-alone dental plans to comply with the certification requirements and consumer protections required for QHPs. As discussed in the preamble of the proposed rule, these standards include: quality reporting, transparency measures,

summary of coverage information, provider network standards, and standards regarding the consumer's experience in comparing and purchasing plans. In addition, stand-alone dental plans should abide by the following consumer protections that will be required to be provided by QHPs, including: the right to an external appeals process, coverage of dental preventive services at no cost, coverage of children up to age 26, and prohibitions against exclusions based on pre-existing conditions and unfair rescissions of coverage. Pediatric dental coverage is a required essential benefit that should be valued as an important component of the health coverage offered through the Exchanges, and should therefore be subject to QHP certification requirements and consumer protections.

Recommendation: Stand-alone dental plans within the Exchange must abide by the certification requirements and consumer protections of QHPs. As discussed in the preamble of the proposed rule, these standards include: quality reporting, transparency measures, summary of coverage information, provider network standards, and standards regarding the consumer's experience in comparing and purchasing plans. In addition, stand-alone dental plans should abide by the following consumer protections that will be required to be provided by QHPs, including: the right to an external appeals process, coverage of dental preventive services at no cost, coverage of children up to age 26, and prohibitions against exclusions based on pre-existing conditions and unfair rescissions of coverage.

Recertification of QHPs- §155.1075

a. Recertification process

We are concerned that the proposed rule gives Exchanges or states full discretion to design their QHP recertification processes. We believe that the final rule should require an active recertification process with a formal annual review of all QHPs by the Exchange. Without such an annual recertification process, plans may fall out of compliance with QHP criteria, exposing consumers to coverage that does not meet legal standards and leading to the expenditure of federal subsidy dollars on products that violate federal law.

Although, as noted in the preamble, a recertification process may be "less intensive than the initial certification process," an annual review that verifies ongoing compliance with certification standards is necessary for all QHPs. The preamble states that rate increase information and benefit design standards must be reviewed annually (including to determine whether the QHP's benefit design, or changes to such design, violates section 1311(c)(1)(A) of the Affordable Care Act). We agree that these criteria must be comprehensively reviewed each year since they are likely to change annually. Additionally, the final rule should require Exchanges to do an annual comprehensive review of plans' provider networks, essential community providers, rating variations, marketing practices and materials, and submission of required transparent information (enrollment, disenrollment, and claims denial information; cost-sharing and payment information for out-of-network coverage, etc.). Annual review of these criteria is critical, as they may change frequently. For example, provider contracts may change annually and providers may move away or otherwise cease to practice at any time, causing a QHP's provider network or access to community providers to become inadequate.

Other QHP criteria, such as accreditation, service areas, applications and notices, enrollment

periods and processes, termination processes, and SHOP standards should also be reviewed annually, but may warrant a less comprehensive annual examination by the Exchange than the criteria listed in the above paragraph. For example, an Exchange could implement a form for plans to submit annually, verifying that they are accredited by an HHS-recognized accrediting body, listing their enrollment periods, submitting any applications, notices, and enrollment and termination forms that they use, and verifying that they meet the other remaining standards. However, Exchanges should still periodically (at least every two or three years) perform a more comprehensive review of these standards and should always investigate any complaints regarding violations of these standards in a timely manner, in accordance with the requirements for ongoing monitoring of plan compliance (§155.1010).

The final rule should also describe how HHS will ensure that Exchanges are complying with the required process for recertifying QHPs. Whether in the final rule or in future regulations on oversight, HHS should codify how it will enforce the requirement that Exchanges have a robust recertification process and outline how HHS will respond if an Exchange does not perform the required annual QHP recertification process.

Recommendation: The final rule should require an annual QHP recertification process in which plans' provider networks, essential community providers, rating variations, marketing practices and materials, and submission of required transparent information are comprehensively reviewed and other certification criteria are verified. HHS should outline how it will enforce QHP recertification requirements for Exchanges.

b. Timing

We support the rule's requirement that Exchanges complete the recertification process for QHPs on or before September 15 of the applicable calendar year. We agree that this deadline will ensure that plans are available for the mid-October annual open enrollment period. We oppose moving the recertification deadline any closer to the start date of the open enrollment period.

Recommendation: The final rule should maintain the September 15 deadline for completion of the QHP recertification process.

Decertification process for QHPs- §155.1080

b. Decertification process

The proposed rule does not explain how HHS will ensure that Exchanges have a robust process for decertifying QHPs. Whether in the final rule or in future regulations on oversight, HHS should codify how it will enforce the requirement that Exchanges have a robust decertification process and how HHS will respond if a state does not implement such a process when plans fail to maintain compliance with QHP standards.

Recommendation: The final rule should describe how HHS will enforce Exchange compliance with section 155.1080.

c. Decertification by the Exchange

We are concerned with the rule's language stating that an Exchange "may" at any time decertify a health plan if the plan is no longer in compliance with QHP certification criteria. To comply with the statutory requirement that all plans available through an Exchange have effective QHP

certifications, we believe that QHPs that are found to be out of compliance with certification standards (through the Exchange's ongoing process for monitoring compliance, during recertification, or otherwise) must be required to remedy their problems within a limited period of time. Plans that are not in compliance should be subject to a system of sanctions, such as that used in Medicaid managed care. Exchanges must be *required* to remove plans' QHP certification and cease to include them in the Exchange if they do not remedy their problems within a limited period of time. The process for plan decertification (Section 155.1080), including the provision of a special enrollment period for a decertified plan's enrollees, must take place at this time. Without this required process, Exchange consumers, many of whom will be receiving coverage funded by federal dollars, will be enrolled in a plan that does not afford them all of the consumer protections that are required by law.

In addition, the preamble states that Exchanges should consult stakeholders, including issuers, when determining how to implement a decertification process. We recommend that "representatives of consumer interests" also be included as an example of stakeholders that should be consulted when implementing a decertification process.

Recommendation: The final rule should require Exchanges to decertify a QHP if the plan is found to be out of compliance with certification standards and does not remedy the situation within a limited period of time. "Representatives of consumer interests" should be included as an example of stakeholders that should be consulted during a decertification process.

d. Appeal of decertification

The proposed rule grants plans that receive notice of a decertification the right to appeal. We recommend that the final rule set a timeline for the appeals process of a decertification so that consumers do not remain in plans that may be out of compliance with the ACA for an unnecessarily long amount of time. We recommend that HHS grant a plan 30 days to file an appeal after a decertification and then grant the entity making the determination 30 days from the submission of the appeal to make a decision. During the appeal process, individuals who are enrolled in a plan that is appealing a decertification should be granted a special enrollment opportunity to seek other coverage, if they choose.

The preamble to the rule states that the "appeal process could be implemented in conjunction with the State department of insurance, by the Exchange on its own, or through a third party entity." We recommend that the rule include standards for entities conducting a decertification appeal process to ensure that they do not have conflicts of interests, particularly since third party entities may be involved. The rule should state that entities that are affiliated with health insurance issuers or health insurance producers, including through employment, family/marriage, organizational membership, or business ties, must not serve a role in determining a decertification appeal.

Recommendation: The final rule should create a required timeline for the decertification appeal process (30 days for a plan to appeal; 30 days from submission for the determination to be made). Individuals enrolled in a plan that is appealing a decertification should be granted a special enrollment period to change plans, if they choose. Standards to prevent conflicted parties from involvement in the appeal determination process should be

implemented in the final rule.

e. Notice of decertification

We support the provision of the rule stating that enrollees in a QHP that has been decertified must receive notice, including notice of a special enrollment period, and be granted the same enrollment opportunities as other individuals who qualify for special enrollment. The notice to enrollees should be provided by mail and other means, provide clear information on the enrollee transition process and other coverage options, and include contact information for the Exchange call center, Navigators, and available consumer assistance programs. HHS should produce a model notice of QHP decertification for enrollees to help Exchanges comply.

Additionally, we believe that individuals whose plan has been decertified (along with other individuals who qualify for special enrollment) should be permitted to change their coverage level from that of their previous plan. Requiring enrollees to remain at the same level of coverage after their plan is decertified may restrict their ability to obtain affordable coverage that meets their needs. For example, coverage at the same level may be unaffordable if the other plans at that level are more expensive than their previous (decertified) plan.

Recommendation: The final rule should require notices to enrollees of decertification to be provided by mail and other means, provide clear information on the enrollee transition process and other coverage options, and include contact information for the Exchange call center, Navigators, and available consumer assistance programs. HHS should produce a model notice of QHP decertification. The final rule should also allow Exchange enrollees who receive a special enrollment opportunity due to a decertification of their plan to change their coverage level, if they choose.

Part 156- Health Insurance Issuer Standards under the Affordable Care Act, including Standards Related to Exchanges

Subpart A- General Provisions

§156.50 Financial support

Our comments on Section 156.50 are similar to those of other consumer advocacy organizations, but reflect Families USA's unique concerns. 156.50 (a) defines a "participating issuer" as "any issuer offering plans that participates in the specific function that is funded by user fees." According to the preamble, "participating issuers" will encompass different segments of health issuers depending on Exchange functions being funded by the user fee. The preamble notes that this provides the Exchange with "flexibility to collect user fees from issuers that benefit in some way from an Exchange and Exchange-related operations," including non-QHP issuers, multi-State plans, and stand-alone dental plans. We strongly support this broad definition. It will create a more level playing field for the Exchange, and therefore a more robust, competitive insurance market than if assessments were only on QHPs. Issuers besides QHPs will benefit from Exchange functions, so states must have the ability to assess them as well.

To be consistent with this sentiment expressed in the preamble, we believe that the definition of a "participating issuer" under Section 156.050(a) should be modified to read, "any issuer offering

plans that is **affected by Exchange functions or other activities related to the Exchange**." Further, to avoid administrative burdens, the rules should clarify that assessments on specific participating issuers to not have to be proportional to the exact Exchange functions that affect them. If assessments on different issuers had to vary based on which Exchange functions affect them, calculating and collecting assessments would be incredibly challenging for states. States would have to independently determine how each issuer is affected by Exchange-related operations (a task that may not be feasible with any degree of accuracy), and issuers would also struggle to understand how an Exchange assessment would apply to them.

Section 156.050(b) requires participating issuers to "remit user fee payments assessed by an Exchange" under section 155.160 of the proposed rule. However, section 155.160 discusses not only "user fees," but also "assessments" to fund ongoing Exchange operations. Therefore, to ensure an Exchange's statutory right to collect assessments from participating issuers, we recommend that the final rule modify Section 156.050(b) to read, "A participating issuer must remit user fee payments assessed by an Exchange or any other assessments, fees, charges, or payments assessed under §155.160 of this subtitle."

Recommendation: The definition of "participating issuer" should be modified to read, "any issuer offering plans that is affected by Exchange functions or other activities related to the Exchange." **The final rule should clarify that assessments do not have to vary for specific issuers proportional to which Exchange functions affect them. Section 156.050(b) should be clarified to read, "A participating issuer must remit user fee payments assessed by an Exchange or any other assessments, fees, charges, or payments assessed under §155.160 of this subtitle," so that it encompasses the broader assessments referred to in section 155.160 of the proposed rule.**

Subpart C- Qualified Health Plan Minimum Certification Standards

§156.200- QHP issuer participation standards

This section sets out the requirements for the issuers of qualified health plans in an Exchange. We support these standards and believe that the inclusion of a provision to protect individuals regardless of "race, color, national origin, disability, age, sex, gender identity and sexual orientation," from discrimination in marketing, outreach, enrollment and other aspects of QHPs is particularly important. We believe this protection should also be reflected in the marketing standards section of the rule (Section 156.225).

However, in several specific areas, including marketing and network adequacy, we recommend that more specific standards be established in the final rule. While the law clearly provides states operating their own Exchanges with significant flexibility to establish the process for certifying qualified health plans and other related requirements, federal rules must ensure that QHPs are held to certain minimum standards no matter where in the country they operate. The federal government will be subsidizing QHP coverage for millions of people and therefore must do all it can to ensure that QHPs provide good-quality coverage, that consumers in QHPs are adequately protected, and that the ability of QHP issuers to prompt adverse selection is greatly minimized.

One glaring omission is that the proposed rule does not codify the statutory requirement, in

Section 1311(c)(1)(A) of the ACA, requiring the Secretary to ensure that QHPs do not employ "benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs." The rule does address this requirement as it pertains to marketing, in §156.225 of the proposed rule. But the final rule must be modified so that it clearly incorporates the prohibition against benefit designs that discourage the enrollment of individuals with significant health needs. Even within the protections and reforms included in the ACA, some insurers are likely to structure their benefits in ways that disadvantage people with significant health needs if they are permitted to do so. This has occurred in Medicare Advantage, where some private insurers were permitted to scale back certain benefits used primarily by sicker individuals, for example by charging much higher copayments for days in the hospital or costly treatments like chemotherapy compared to traditional Medicare fee-for-service, but maintaining actuarial equivalence by lowering cost-sharing for more common services like office visits.[15] This practice in Medicare has been significantly reduced at least in part by policy changes at CMS and by statutory changes. In the Exchange, QHP issuers may have even greater leeway than Medicare Advantage plans to design their benefits in ways that will discourage enrollment by people with significant health needs. The requirement for the Secretary to ensure that QHPs do not employ benefit designs that have this effect is one of the critical ways that HHS can appropriately protect consumers and minimize adverse selection that would harm Exchanges.

We note another glaring omission. The proposed rules do not codify the statutory requirement under section 1312(c) that requires all health insurance issuers in the individual market and separately in the small group market to establish a single risk pool across all plans inside and outside the Exchanges. Such a requirement should be codified in the proposed rules related to premium variation in §156.255.

The final rule should also require QHPs to refer any complaints they receive from Exchange enrollees (particularly those who are eligible or believe they are eligible for subsidies) to the relevant Exchange. It is possible that a consumer would contact a plan with a complaint about the coverage or with a complaint related to an eligibility determination for premium credits or cost-sharing reductions, rather than going to an Exchange. In such instances, the QHP should be required to inform the Exchange about such complaints. This can help ensure that individuals are able to utilize the Exchange's appeals process for eligibility determinations, when applicable, and that the Exchange is aware (for purposes of consumer satisfaction ratings and other consumer tools) when a plan has received complaints.

Recommendations: Explicitly require QHP issuers to avoid employing benefit designs that have the effect of discouraging enrollment in a particular plan. We suggest inserting an additional issuer requirement at §156.200(b). This new requirement, numbered (8) would read, "Avoid employing benefit designs that have the effect of discouraging the enrollment in such plans by individuals with significant health needs."

Require QHPs to notify the relevant Exchange when a QHP enrollee makes a complaint directly to the insurer, whether the complaint is related to plan actions, coverage issues, or eligibility determinations.

§156.210- QHP rate and benefit information

a. General rate requirement

We support the requirement that a QHP issuer must set rates for an entire benefit year (or plan year in the SHOP). This is critical for protecting consumers from unpredictable mid-year premium increases that would also make premium subsidy payment incredibly burdensome for the federal government. We recommend that the final rule clarify that this requirement applies not only to rates for enrollees who enter a QHP during the open enrollment period, but also to those who enter during special enrollment.

Recommendation: The final rule should clarify that a QHP's rate for the benefit year applies to all enrollees, whether they enroll during open enrollment or a special enrollment period.

b. Rate and benefit submission

The preamble states that HHS seeks to align the required data elements that plans must submit to the Exchange regarding rates and benefits with information already collected in state review and rate filing processes. We agree with this goal in order to improve efficiency. However, Exchanges must have complete rate information from carriers, so any rate information not collected by the state and then delivered to the Exchange must still be provided to the Exchange. Existing required information should not create a ceiling for the level of rate and benefit information that is required for submission to the Exchange. Additionally, the final rule should specify by when each year QHPs must provide rate, benefit, and cost-sharing information to the Exchange. The submission deadline should be prior to the deadline for QHP certification and/or recertification.

Recommendation: The final rule should clarify that when leveraging existing data collection processes, Exchanges must still obtain complete rate information from QHPs, even if such information is not already provided to the state. It should also specify the submission deadline for QHP rate and benefit information.

c. Rate justification

We support Exchanges leveraging existing rate review processes for obtaining rate justification information, but recommend that the final rule clarify that if existing processes do not provide sufficient information for an Exchange to consider a rate increase in the QHP certification or recertification process, the QHP must submit further information to the Exchange.

The preamble proposes the development of a standard for "prominently posting" rate increase justifications on insurers' websites. We would support such a standard and recommend its inclusion in the final rule. Further, we recommend that Exchanges post links to any rate increase justifications for a plan next to the plan's premium information on the Exchange website.

Recommendation: The final rule should clarify that QHPs must provide complete rate increase justification information to Exchanges, even if such information exceeds that required for existing rate review processes in the state. The final rule should include a standard definition for "prominently posting" rate increase justifications on insurer websites, and Exchange websites should be required to post links to such justifications next to QHP premium information.

§156.220- Transparency in coverage

a. Required information

The proposed rule requires QHP issuers to provide the following information:

(1) Claims payment policies and practices
(2) Periodic financial disclosures
(3) Data on enrollment
(4) Data on disenrollment
(5) Data on the number of claims that are denied
(6) Data on rating practices
(7) Information on cost-sharing and payments with respect to any out-of-network coverage
(8) Information on enrollee rights under Title I of the ACA

We support the codification of all the statutory categories.

HHS should provide uniform standards and methodologies for reporting these measures to facilitate compliance and assure issuers they face the same requirements across markets and states. At a minimum, HHS should establish uniform definitions and clarify the timeframe the measure should cover. HHS should also clearly state that this information must be reported at the policy (i.e. product) level, rather than aggregated to a higher level (e.g. state or market for each carrier). HHS should also consider whether and how any of these measures should be disaggregated at a more granular level (e.g. for enrollment and disenrollment data for QHPs sold inside and outside the Exchange, indicating what percentage enrolled through the Exchange). In addition, while this information is required to be submitted in plain language, HHS should consider whether hard data should also be submitted for any measures. More granular information can be used to check the accuracy of the plain language information as well as to monitor compliance with other legal requirements.

With regards to measure 8, information on enrollee rights under Title I of the ACA, such information should be tailored to the plan or policy based on how it is regulated as enrollee rights differ based on how a plan is regulated (e.g. as an individual policy, small group plan, or large group plan, as well as self-insured vs. fully insured). If a plan or policy is grandfathered, the information should clearly state both the protections that apply and those that do not.

Recommendations: HHS should establish uniform standards and methodologies for reporting these measures by policy to facilitate compliance and assure issuers they face the same requirements across markets and states. HHS should consider requiring the collection of hard data in addition to plain language information as appropriate.

b. Reporting requirement

The proposed rule requires a QHP issuer to submit, in an accurate and timely manner, the transparency of coverage measures to the Exchange, HHS, and the state insurance commissioner, and to make this information available to the public. As discussed in comments on §155.1040(a), we support the codification of this statutory requirement, but would encourage HHS to provide additional guidance on how this should be operationalized.

As we have previously stated, HHS should establish a clear timeframe for when issuers must submit this information and how often. The preamble considers requiring QHPs to simply "make such information available to the Exchange and other entities," instead of requiring QHPs to "submit" this information. We oppose this proposal and instead recommend that issuers be required to submit this information annually, aligned to the extent feasible with the timing of certification and recertification of QHPs. HHS should also create a process for how to handle late or inaccurate submissions, and ultimately assess a penalty on non-compliant issuers with respect to each plan or policy for which they are not in compliance. At a minimum, Exchanges should have the authority to enforce this requirement with respect to QHPs, although HHS should also consider what role the other intended recipients of this information have in enforcement.

Second, HHS should consider whether Exchanges can play a role as an aggregator and disseminator of this information for QHPs (and whether HHS could play a similar role when applying this requirement beyond QHPs). Could QHPs submit this information through a single portal offered by the Exchange or HHS that then directs it to the other entities? In §155.205(b)(1), HHS begins to move in this direction, requiring that the transparency of coverage measures for QHPs be presented on an Exchange's website. Consumers will benefit from having this information available from all plans in one place. However, even when Exchanges or HHS are making transparency of coverage information available on a public website, issuers must be required to provide transparency information directly to a consumer in a timely manner upon request, as discussed in greater detail §156.220(d).

Recommendations: HHS should require QHP issuers to submit this information annually, either before or when a QHP seeks certification or recertification. QHP issuers should be subject to an enforcement process. In addition, HHS should consider utilizing Exchanges as an aggregator and disseminator of transparency in coverage information to minimize burden and increase efficiency of the reporting process.

c. Use of plain language

The proposed rule requires QHP issuers to make sure that the required information is provided in plain language as defined in §155.20 ("Plain language means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing").

We strongly support this requirement and look forward to working with HHS and DOL to develop the guidance on best practices for plain language writing. Information should be provided using clear, consistent, and concise language written at the lowest reasonable education level, and steps should be taken to make it understandable by individuals with low literacy and numeracy levels. The best practices should also take into consideration additional barriers to understanding including, but not limited to, limited English proficiency (LEP); cultural differences; sensory, intellectual, and other disabilities; low health literacy levels; and low levels of familiarity with insurance and financial terms and concepts. HHS and DOL should work with NAIC to identify any lessons learned in its work to develop its recommendations on the summary of benefits and coverage documents. In addition, the agencies should engage individuals and organizations with expertise in plain language writing, as well as language and disability access. HHS and the Exchanges should also regularly solicit feedback from consumers about the

usability of the information provided and make adjustments to the best practices guidance as appropriate.

Recommendations: QHP issuers should be subject to an enforcement process for the plain language requirement. In drafting guidance on best practices for plain language writing, HHS and DOL should work with individuals and organizations with expertise in plain language writing and language and disability access, as well as use lessons learned from NAIC's work developing recommendations for a template summary of benefit and coverage document.

d. Enrollee cost-sharing transparency

The proposed rule requires that a QHP issuer must make available the amount of enrollee cost-sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon request of the individual. At a minimum, such information must be made available to such individual through an internet website and such other means for individuals without access to the internet.

HHS should clarify and elaborate on this section.

The transparency in coverage measures outlined under §156.220(a), which include information on cost-sharing respective to out-of-network providers, is required to be listed on the Exchange website in §155.205(b). The latter section also proposed that a QHP's summary of benefits and coverage, which will include information on cost-sharing for participating providers, be made available through the Exchange website. Both of these requirements are important to ensuring that consumers can easily access summary information about cost-sharing requirements, and must be listed by specific benefit category (e.g. primary care visit, specialist visit, emergency room services, etc.).

However, as contemplated under this section, consumers should also be able to access information about cost-sharing for a specific item or service. They may want this information while enrolled in a plan prior to scheduling an appointment or filling a prescription, or may want this information when comparing plans (for instance, if they have a chronic condition and know that they will need to use a specific item or service once enrolled).

In such instances, the information made available on the Exchange website may be insufficient and the final rule should ensure that consumers can request this information directly from QHPs. We urge HHS to specify that QHPs must provide this information free of charge as soon as practicable but no later than seven days following the request. The consumer should be able to make this request online, but also by phone, fax, or mail. Consumers should also be able to choose how they would prefer to receive the information. Recognizing that not everyone has access to the internet and many people nonetheless prefer to receive hard copies of information, a paper copy of this information should always be available.

We also encourage HHS to extend this requirement to all of the transparency in coverage measures outlined under §156.220(a), to ensure access for individuals who do not use or have access to the internet.

Recommendation: HHS should require QHPs to provide information about cost-sharing with respect to a specific item or service provided by a participating provider, as well as all of the transparency information transparency in coverage measures outlined under §156.220(a), to individuals free of charge upon request. This information should be provided as soon as practicable, but no later than seven days following the request. QHPs should enable consumers to make this request online, but also by phone, fax, or mail. Consumers should also be able to choose how they would prefer to receive the information, with a paper option always available.

§156.225- Marketing of QHPs

a. State law applies

We support the requirement that, like for all state laws and regulations, a QHP issuer must comply with state laws and regulations regarding marketing by health insurance issuers. Additionally, we support the preamble's statement that an Exchange should consider a QHP issuer's marketing practices in determining whether offering a QHP is in the best interest of consumers. This consideration should be required under section 155.1000 as well, as our comments for that section reflect.

b. Non-discrimination

The proposed rule codifies the statutory requirement that QHP issuers may not employ marketing practices that discourage the enrollment of individuals with significant health needs. In a glaring omission, however, the proposed rules do not codify the additional requirement under section 1311(c)(1)(A) that QHPs may not employ *benefit designs* that have the same effect of discouraging enrollment by individuals with significant health needs. Such a requirement must be codified and could be included in section 156.200 of the proposed rules.

While we agree that it is important that the same minimum marketing requirements exist in the outside market as for QHPs to the greatest extent possible, we also believe it is critical that the final rule upholds the statutory requirement that plans meet minimum marketing requirements in order to receive QHP certification. Exchanges will serve many consumers who have little experience buying health insurance in the commercial market, and marketing requirements should be crafted with their needs in mind. To that end, we support the proposal in the preamble for a broad prohibition against unfair or deceptive marketing practices by all QHP issuers and their officials, agents, and representatives. This requirement would ensure that plans that engage in unfair or deceptive marketing cannot be certified as a QHP. We recommend that the final rule adopt this prohibition.

In addition to a broad prohibition against unfair or deceptive marketing practices, we believe that there are certain marketing tactics that have been abused with enough regularity that they should be prohibited outright for QHPs. These include distributing purposefully misleading or confusing marketing materials, conducting enrollment outreach in some geographic areas and not in others, any form of targeted door-to-door, telephone, or cold-call marketing, and offering gifts or meals to potential enrollees. These recommendations are informed by experiences with Medicaid managed care and private Medicare plans. In Medicare Advantage, seniors were pressured to enroll in policies that did not include their primary care doctor or plans that had misleading cost-sharing requirements. The Medicaid managed care plan rules prohibit many of these types of

tactics as well.

Each Exchange should also be required to submit, as part of its plan for approval, an outline of the compliance measures it will adopt to ensure that QHPs meet marketing requirements.[16] The Exchange should detail the extent to which it will employ tools that have historically been used to combat marketing abuses. There are many recent examples for Exchanges to draw on when they develop this section of their plan for approval by HHS. CMS instituted a secret shopper program and began reviewing the material in the enrollment packages in Medicare Advantage plans to make sure plan benefits are not misrepresented. Other tactics for Exchanges to consider include consumer education seminars and programs to contact consumers after they have purchased a plan to confirm they are enrolled in the plan they think they purchased.

We believe Exchanges must also be mindful of entities impersonating a QHP or an insurance Exchange, or misusing these terms in ways that are likely to mislead consumers. For example, a website could claim to be a state Exchange, or an issuer could use terms such as "silver" or "platinum" in its product names, even if the products are not certified QHPs that are offered in an Exchange. This could mislead consumers into thinking they are getting a certified product from a certified Exchange, when in fact the product may not provide them the protection they need. Michigan's draft Exchange legislation, SB 693, addresses this by stating that entities shall not incorporate, file, register, or otherwise form in the state using a name that is the same as or deceptively confusingly similar to the name of the Exchange.

Finally, the final rule should require Exchanges to take action when a certified QHP violates the marketing requirements. Exchanges should be required to ensure that any QHPs violating the marketing requirements come into compliance within a limited amount of time. Plans that are not in compliance should be subject to a system of sanctions, such as that used in Medicaid managed care. Exchanges must be required to remove plans' QHP certification and cease to include them in the Exchange if they do not remedy their problems within a limited period of time. The process for plan decertification (Section 155.1080), including the provision of a special enrollment period for a decertified plan's enrollees, must take place at this time.

Recommendation: The final rule should codify the statutory requirement that QHPs may not employ *benefit designs* that discourage enrollment of individuals with significant health needs. The rule should also institute a broad prohibition against unfair or deceptive marketing practices by all QHP issuers and their officials, agents, and representatives. Abusive practices like distributing purposefully misleading or confusing marketing materials, conducting enrollment outreach in some geographic areas and not in others, and any form of targeted door-to-door, telephone, or cold-call marketing should be specifically prohibited. Each Exchange should also be required to submit, as part of its plan for approval, an outline of the compliance measures it will adopt to ensure that QHPs meet marketing requirements. The final rule should also require Exchanges to take action when a certified QHP violates the marketing requirements.

§156.230- Network adequacy standards

b. Notice to applicants and enrollees

Families USA supports the requirement that a QHP issuer must make its provider directory for a

QHP available to the Exchange for publication online and to enrollees in hard copy upon request. The rule states that hard copies must be made available to "potential enrollees." We recommend that "current enrollees," as referenced in addition to "potential enrollees" in the preamble, be added to the actual language of the rule as a population to which a QHP issuer must make a provider directory available in hard copy upon request.

We support the reference in the preamble to the option for Exchanges to establish a "consolidated provider directory through which a consumer may search for a provider across QHPs." Such a directory would be extremely useful to consumers shopping for coverage. We urge HHS to encourage Exchanges to take this approach to providing provider directories and to help states acquire the information and technology needed to do so, including through sharing resources across states.

In addition, Exchanges are required to comply with Title VI of the Civil Rights Act, Section 508 of the Rehabilitation Act, and Section 1557 of the ACA. As such, they should be required to ensure that provider directory information is available in a variety of ways and formats to meet the needs of enrollees and potential enrollees with disabilities and limited-English proficiency.

Finally, the preamble seeks comments on standards to ensure that QHP provider directories are kept up to date. It is critical that enrollees have access to accurate, timely information on both which providers are generally in a plan's network and which providers in the network are not accepting new patients. Therefore, we recommend that QHPs be required to update their electronic and hard copy provider directories based on both of these criteria at least quarterly. QHPs should also be required to make a good faith effort to update online provider directories more frequently when they know that a provider has left their network. Families USA has received reports from consumers of online provider directories that include providers who have had their licenses revoked or have passed away. QHPs should make an effort to remove such providers and others who they know are no longer in their network from online provider directories as soon as they receive information that the provider will no longer be in-network. In addition, electronic and paper provider directories should include language advising an enrollee or potential enrollee to call a provider or facility to confirm that the provider is still participating in the QHP network and accepting new patients before seeking care.

QHPs should also be required to notify enrollees under active treatment with a provider or with scheduled procedures or hospital admissions if their provider or facility has submitted a termination notice to the QHP or will otherwise be leaving the QHP network. This will allow the enrollee to make alternative plans for treatment or the QHP to work with the terminating provider to make sure the services are treated as covered in-network services and enrollees are not subject to out-of-network cost sharing requirements.

Recommendations: The final rule should include "current enrollees" as a population to which a QHP issuer must make a provider directory available in hard copy upon request. The final rule must require QHPs to address the needs of enrollees and potential enrollees with diverse cultural and ethnic backgrounds, limited-English proficiency, and physical and mental disabilities in the provision of provider directories. QHPs should be required to update their electronic and hard copy provider directories at least quarterly and should be required to make a good faith effort to update their online directory more frequently when

they know that a provider has left their network. Finally, the final rule should require QHPs to notify enrollees under active treatment with a provider or with scheduled procedures or hospital admissions if their provider or facility has submitted a termination notice to the QHP or will otherwise be leaving the QHP network.

§156.235 Essential community providers

a. General requirement

The proposed rule requires QHP issuers to "include within the provider network of the QHP a sufficient number of essential community providers, where available, that serve predominantly low-income, medically underserved individuals." Essential community providers (ECPs) often operate at capacity and in some communities represent the only source of medical care for a large share of the population. Limiting which ECPs a QHP must contract with would therefore remove access for QHP enrollees in the community to a very critical provider. Therefore, we recommend that the final rule clarify that QHPs must contract with all ECPs in their service area on an "any willing provider" basis. Furthermore, HHS should require QHPs to contract with ECPs for the full range of covered services that the ECP can provide to patients. Such a requirement would support continuity and coordination of care for low-income consumers.

We understand the concerns regarding how this requirement would work in the context of a "staff model" managed care organization or plans in similar situations. However, we believe this broad requirement to contract with ECPs would fit within most models of coverage. If staff model plans are exempt from the ECP requirement, they should be required to provide evidence of serving low-income populations, complying with national standards for providing culturally and linguistically appropriate services, and implementing a plan to address health disparities, as discussed in the preamble.

Recommendation: Require QHPs to contract with essential community providers in their service area on an "any willing provider" basis for the full range of covered benefits that the ECP is able to provide.

§156.250- Health plan applications and notices

This section references 155.230(b) as the standards for QHP issuers to provide accessible and readable applications and notices. We support this requirement, and recommend that the rule further define accessibility. In addition, QHP issuers should be required to ask enrollees their preferred language on their initial application form and should maintain this information in relevant databases for future use.

Notices should be translated into languages spoken by 500 LEP individuals or 5 percent of individuals who are included in an Exchange or QHP's service area, whichever is less. These are language thresholds that HHS and DOJ use in other programs, such as for marketing of Medicare Part D plans. All Exchange and QHP notices should also include translated taglines in 15 languages that provide information on how to access translated materials and oral language assistance.

R**ecommendation: The final rule should specify LEP requirements for applications and**

notices and require QHPs to collect information about enrollees' preferred languages so that they can send future notices in the appropriate language for enrollees that meet language thresholds.

§156.255- Rating variation

a. Rating areas

Families USA supports the statement in the preamble that rating areas will be applied consistently inside and outside of the Exchange. We recommend that this be a codified requirement in future rulemaking.

Recommendation: HHS should codify that rating areas must be applied consistently inside and outside of the Exchange.

b. Same premium rates

We support the statement in the preamble that an issuer must charge a premium that uses underlying rating assumptions that account for all expected enrollees of a QHP, including individuals who enroll outside of the Exchange and individuals who enroll through an agent or broker. We recommend the final rule codify the requirement of section 1312(c) of the ACA that requires all health insurance issuers in the individual market and separately in the small group market to establish a single risk pool across all plans inside and outside of the Exchanges. This critical requirement is not codified in the proposed rule.

In addition, to prevent possible gaming of the requirement that issuers charge the same premium rate without regard to whether a "plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent," we urge HHS to more clearly define what meets the definition of a "plan" for this purpose. Such clarification is necessary to prevent an insurer that is offering two plans with very minor differences from charging different premiums for what is essentially the same plan outside versus inside the Exchange. The proposed rule defines "health plan" as a "discrete combination of benefits and cost-sharing." We interpret this to mean that a plan is different from another plan only if it includes such a discrete combination. It follows, then, that a plan offered outside the Exchange cannot be priced differently than an Exchange QHP simply because it is given a different name. But the "discrete combination of benefits and cost-sharing" standard may not be clear enough to determine the treatment of plans that charge slightly different deductibles or co-payments but offer the same benefits. We are concerned that if minor differences allow plans to be treated as different plans for purposes of the "same premium rates" provision (even if the differences have little or no justifiable impact on premiums), it will lead to a proliferation of numerous plan designs that do not differ in meaningful respects, but allow insurers to avoid the "same premium rates" requirement. This would confuse consumers and lead to adverse selection. Therefore, we recommend that the final rule state clearly that plans must vary substantially as to benefits and cost-sharing in order to be considered different plans that can be priced using different rating assumptions.

Finally, we recommend that the rules clarify that subjecting consumers to a "user fee" for enrolling in Exchange coverage, whether this fee is collected by the Exchange or by a QHP issuer, violates the requirement that premium rates be the same whether a consumer purchases a

given QHP inside or outside of the Exchange. Failure to implement this rule would result in an unlevel playing field where consumers would end up paying more for the same coverage if they obtained it through the Exchange than if they purchased it through the outside market. This would deter consumers from seeking coverage through the Exchange, undermining its ability to be a robust marketplace.

Recommendation: The final rule should codify the requirement of section 1312(c) of the ACA that requires all health insurance issuers in the individual market and separately in the small group market to establish a single risk pool across all plans inside and outside of the Exchanges. It should also clarify that plans must vary substantially as to benefits and cost-sharing in order to be considered different plans that can be priced differently outside versus inside the Exchange. The final rule should state that subjecting consumers to a "user fee" for enrolling in Exchange coverage, whether this fee is collected by the Exchange or by a QHP issuer, violates the requirement that premium rates be the same whether a consumer purchases a given QHP inside or outside of the Exchange and is therefore prohibited.

c. Rating categories

The proposed rule includes four family rating categories: 1) individuals; 2) two-adult families; 3) one-adult families with a child or children; and 4) all other families. We support that under these categories, families do not have to pay a higher premium due to having more children. This is important because having more children does not mean that a family has more income to spend on coverage.

It would appear that under this proposed structure, child-only plans would fit under the first category. We are interested in the implications of this versus a separate child-only rating category. It is our understanding that insurers typically use a separate rating category for child-only plans. If the Exchange included child-only plans in the general individual category, would there be an unlevel playing field with the outside market? Would child-only plans be less expensive in the outside market, causing adverse selection against the Exchange? We recommend that HHS take these questions into consideration when crafting the final rule. In addition, we recommend that the final rule clarify that categories two and four (two-adult families and all other families, respectively) include domestic partners and people in civil unions, particularly because these may be required categories for coverage under state laws.

The preamble seeks comments on how to structure family rating categories in light of the statutory requirement that age-rating and tobacco rating may only be applied as attributable to each family member. We support this requirement. For tobacco rating, HHS may want to consider a flat tobacco surcharge for each family member that smokes.

While we support the statement in the preamble that offering uniform family rating categories will maximize competition between health plans based on price and quality, and limit premium variation within families of similar types, we are concerned that the proposed rules do not adequately achieve these aims and could create significant problems for families using premium tax credits to purchase a QHP. Under the proposed rules, QHP issuers must offer coverage to all four family groups listed above, but issuers have the discretion to decide to separately offer coverage to all four family categories or to combine coverage categories such that, for example,

they include both one-adult and two-adult families in the broad category of family coverage. Under this scenario, most carriers in an Exchange might cover all types of families in the broad family coverage category, while only a few carriers might offer coverage for one-adult families under a separate rating category. It would even be possible for only one QHP issuer in an Exchange to offer one-adult family coverage.

This would create significant problems for families using premium tax credits to purchase a QHP through the Exchange. Under the proposed IRS regulations, a family's premium tax credit is calculated based on the benchmark cost of the second lowest cost silver plan for the family category that most specifically describes its family's composition. If an Exchange only has one QHP that offers one-adult family coverage, there would be no second lowest cost silver plan available in that category. Therefore, what plan would be used to calculate a family's premium tax credit?

Further, in Exchanges with a limited one-adult family market, one-adult families' premium tax credits could be calculated based on the premium cost of substantially cheaper but also less robust plans than those offered in the general family market. Even with their premium tax credits, one-adult families that need more comprehensive coverage than the one-adult family market offers may still be unable to afford the more comprehensive plans offered by carriers that would place them in the general family market. We recommend that the final rule state that a QHP issuer must cover all four family categories discreetly, in order to maximize competition equally across all markets and to ensure equitable consumer choice across all family categories. Further, to create a level playing field, this requirement should also be in place for the individual and small group markets outside of the Exchange.

Finally, the proposed rule is not clear as to whether a QHP issuer must offer *all* QHPs to all family rating categories, or whether the issuer must just provide coverage to all family categories across all of its offerings. We recommend that, at the very least, the final rule state that QHP issuers must offer at least one silver and one gold plan to all family rating categories.

Recommendation: HHS should consider whether adding a "child-only" family rating category would be beneficial to consumers and to the stability of the Exchange. The final rule should clarify that domestic partners and people in civil unions are included in the categories of "two-adult families" and "all other families." HHS should consider a flat surcharge for the purposes of applying the allowable tobacco rating to individual family members. The final rule should require QHP issuers, along with carriers in the individual and small group markets outside of the Exchange, to offer coverage to all four family categories discretely, rather than allow issuers to combine family categories. It should also clarify that QHP issuers must offer at least one silver and one gold plan to all family rating categories.

§156.260- Enrollment periods for qualified individuals

This section requires plans to abide by standards set forth in 155.410(b), (c), (d), (e), and (f). Please see our comments on those sections.

§156.270- Termination of coverage for qualified individuals

We reiterate our comments regarding section 156.270, which also apply to this section. Reading section 156.270 and section 155.420 together, we recommend that you clarify what notices a person will receive prior to termination for nonpayment of premiums, and that you add a section regarding underpayment of premiums. Enrollees who are delinquent in their payments and then fail to pay by the conclusion of their grace period should receive several notices. Utilities, telephones and cable television companies routinely send out multiple notices prior to a termination, and health plans should similarly give consumers every opportunity to prevent discontinuation. First, each month that their premiums are delinquent, enrollees should receive notice of the amount of premiums due, that premiums are delinquent, that their enrollment may be terminated if they are not paid by the conclusion of the grace period, and that they should notify the Exchange or QHP if they are intending to terminate their enrollment so that they will not continue to receive advance premium credits. Second, a month before termination will be effective (using the time frames in section (4)), people should receive notice that termination is about to occur. This notice should include the reason for termination, a citation to the regulation, information about the possible consequences of not maintaining minimum essential coverage, and information about appeal rights and available consumer assistance. Both types of notice should meet standards for language access.

We are concerned that people who do not understand their responsibility to notify the QHP or the Exchange that they are voluntarily terminating coverage, and instead simply stopped paying premiums, could face reconciliation because advance payments will continue on their behalf. If the person submits no claims for the three month grace period, we suggest that the advance payments for that period be withdrawn from that person's tax records.

Finally, section 155.420 provides for reasonable accommodations for certain people who might have difficulty keeping track of monthly payments. Please clarify that the requirement in 156.270 (c)(2) to apply grace periods similarly to people in similar circumstances does not preclude plans from making reasonable accommodations.

Recommendation: The final rule should provide for multiple notices prior to termination for nonpayment that inform people of the consequences and their rights and provide additional safeguards so that a person who has not paid their share of premiums nor used a plan's services during a grace period will not be subject to overpayments of premium credits during that period. It should also clarify that the provision of reasonable accommodations pursuant to section 156.270 does not violate the requirement to apply grace periods similarly to people in similar circumstances.

§156.275 Accreditation of QHP issuers

a. General Requirement

The proposed rule requires QHP issuers to be accredited on the basis of local performance of their QHPs in a number of categories by an accrediting entity recognized by HHS. Families USA supports the intention stated in the preamble to release future rules on which accrediting entities will be recognized by HHS as soon as possible to facilitate a timely QHP certification process. In the preamble, HHS solicits comments on the standards by which HHS should recognize accrediting bodies. To ensure that accreditation is meaningful for consumers, we recommend that

HHS include the following as minimum standards for recognizing accrediting bodies:

- The accrediting body must require plans to report performance on the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS). HEDIS and CAHPS are national standardized tools used to, respectively, measure performance on important dimensions of care and service and assess patients' experiences of care. The accreditor should also audit the reported measures to ensure accurate results.
- The accrediting body must publicly report accreditation results, including performance on HEDIS and CAHPS, so that consumers and health plan purchasers are informed about both cost and quality when picking a QHP.
- The accrediting body must review a number of health plan processes important to consumers, including, but not limited to, those related to marketing practices, appeals processes, utilization management, quality improvement, patient information programs, member privacy, and language access services.
- The accrediting body must maintain network adequacy standards that are equivalent to or more robust than the National Association of Insurance Commissioner's (NAIC's) Managed Care Plan Network Adequacy Model Act.

Families USA supports the requirement that QHP issuers release to the Exchange and HHS a copy of their most recent accreditation survey and any survey-related information that HHS requires, including corrective action plans and summaries of findings. The availability of this information is essential for the Exchange and HHS to conduct oversight of QHP compliance with section 156.275.

Further, consumers and purchasers of care want and need to know about health plan quality and accreditation. Therefore, we urge HHS to require Exchanges to publish consumer-friendly accreditation information on their websites, using a method such as NCQA's star ratings broken down by categories that are meaningful to consumers (i.e. Access and Service, Qualified Providers, Staying Healthy, Getting Better, and Living with Illness). QHPs' HEDIS and CAHPS scores should also be posted on Exchange websites. If QHPs are not yet accredited, this should be reported, along with information on what accreditation means and the expected date of the QHP's accreditation.

Recommendations: The rules for accreditation of QHPs should state that HHS-recognized accrediting bodies must report plan performance on HEDIS and CAHPS; publicly report accreditation and quality reporting results; review health plan processes related to marketing practices, appeals processes, utilization management, quality improvement, patient information programs, member privacy, and language access services; and require maintenance of network adequacy standards that are at least equivalent to the NAIC's Managed Care Plan Network Adequacy Model Act. Additionally, Exchanges should be required to publish consumer-friendly QHP accreditation and quality information on their websites. If QHPs are not yet accredited, this should be reported on the Exchange website.

<u>b. Time frame for accreditation</u>

Families USA supports the requirement that QHP issuers must comply with accreditation timelines outlined in Section 155.1045 of the proposed rule. In our comments on that section we

recommend that HHS set a national one-year maximum post-certification accreditation timeline, instead of allowing individual Exchanges to set the timeline. We support the codification of a requirement that issuers must always maintain accreditation if they are offering QHPs.

§156.280 Segregation of funds for abortion services

We urge HHS to interpret the "special rules" for certain QHPs that provide coverage of abortion services in ways that ease administrative burden for insurers, minimize the costs of compliance, and ensure that consumers can get the health care they need without needless confusion and delay.

e. Prohibition on the use of Federal funds

The ACA requires certain QHP issuers that provide coverage of abortion services to "collect … separate payments" for the amount of the coverage attributable to the cost of abortion services and the amount of the coverage attributable to all other covered health services. We urge HHS to make clear in its final rule that a QHP issuer satisfies this requirement if it issues an itemized bill that separates the costs of abortion coverage from the costs of all other coverage and collects the required separate payments through a single transfer of funds in response to the itemized bill. This method of collecting payments would be in line with the common and widespread insurance industry practice of sending a consumer with multiple insurance policies—life, disability, or homeowners insurance—an itemized bill for payments due on all of his or her policies, and for the consumer to make each of the separate payments using a single transfer or funds. An alternative interpretation of Section 1303 would unnecessarily complicate the payment process and confuse consumers. Moreover, a more complicated scheme would raise compliance costs for insurers, which would pass such costs on to consumers in the form of higher premiums. An interpretation in line with industry practice also achieves a critical goal of the Affordable Care Act: easing enrollment in coverage by lowering administrative barriers and reducing costs.

We also urge HHS to clarify that insurers providing coverage of abortion services are only required to collect separate payments for these services from consumers who receive premium credits, rather than from all consumers. The purpose of this section of the statute, as reflected in the title of this subsection in the rules ("Prohibition on the Use of Federal Funds"), is to prevent federal funds from being used to pay for abortion services. Requiring insurers to separate the costs of abortion coverage from the costs of other coverage when no federal funds are involved does not reflect the statute and would impose unnecessary burdens on plans and consumers.

§156.285 Additional standards specific to the SHOP

a. SHOP rating and premium payment requirements

Section 156.285 mirrors Subpart H by requiring QHP issuers in a SHOP to comply with rate setting timelines established in section 155.705, which we recommend allows SHOP rate increases no more frequently than quarterly. We support the provision that SHOP QHP issuers must charge the same contract rate for a plan year.

b. Enrollment periods for the SHOP

The preamble solicits comment on whether to require QHPs in the SHOP to allow employers to offer dependent coverage. We support this proposal, as we believe it will make the SHOP more attractive to employers who may want to provide dependent coverage to their workers. Further, it

will create a level playing field for SHOP carriers so that no adverse selection occurs between carriers that do and do not offer dependent coverage to small business employees.

c. Enrollment process for the SHOP

We support the requirements that SHOP QHP issuers comply with enrollment processes outlined in other sections of the proposed rule. In particular, we support the codification of the requirement that all qualified employees of a SHOP employer must be enrolled consistent with the plan year of the applicable qualified employer, meaning that (as stated in the preamble) "if an employee is hired mid-plan year, the QHP issuer would issue an abbreviated policy for the duration of the employer's plan year" so the that enrollee will be eligible for open enrollment at the end of the plan year.

d. Termination of coverage in the SHOP

In addition, the final rule should clarify that workers who leave a job with an employer in the SHOP are eligible for COBRA coverage or state continuation (mini-COBRA) coverage, where applicable, in the SHOP plan through which they were receiving employer coverage. This right will provide workers the option to receive continuous coverage with the same provider network and the same benefits. However, some workers may prefer to move directly into the individual Exchange, where they may be eligible for income-based subsidies, so workers must still be granted special enrollment into the individual Exchange even if they have an offer of COBRA.

Recommendation: The final rule should require QHPs in the SHOP to allow employers to offer dependent coverage. It should also clarify that workers leaving jobs with employers in the SHOP are eligible for COBRA or mini-COBRA coverage, where applicable.

§156.290- Non-renewal and decertification of QHPs

a. Non-renewal of recertification

Families USA supports the requirements that QHP issuers electing not to recertify with the Exchange must notify the Exchange before the beginning of the recertification process, fulfill their obligation to cover each enrollee through the end of the plan or benefit year, and fulfill data reporting obligations from their last year in the Exchange.

b. Notice of QHP non-renewal

Families USA supports the proposal in the preamble to develop an enrollee non-renewal notice that provides at least 90-days warning of a QHP non-renewal and includes information on the enrollee transition process and other coverage options through the Exchange. Plans preparing for non-renewal of QHP certification should be required to provide such notice to all enrollees by mail in the enrollee's primary language and provide notice in other formats to ensure that enrollees have ample time to prepare for obtaining new coverage. The notice should clearly state that an enrollee's benefits in the non-renewing plan will continue until the end of the benefit or plan year so that people do not incorrectly believe that their coverage is ending immediately. The notice should also include contact information for the Exchange call center, Navigators, and available consumer assistance programs so that enrollees can get answers to any questions they have regarding transitioning to new coverage. HHS should produce a model notice of QHP non-renewal for enrollees that meets these standards.

Recommendation: The final rule should require QHPs declining to renew their Exchange certification to provide 90-days advance notice to enrollees, including information on the enrollee transition process and other coverage options, contact information for the Exchange call center, Navigators, and consumer assistance programs, and a clear statement that coverage under the non-renewing plan is still effective until the end of the plan or benefit year. HHS should produce a model notice of QHP non-renewal that meets these standards.

c. Decertification

Families USA supports the requirement that a QHP issuer that has been decertified must terminate coverage for QHP enrollees only after the Exchange has notified enrollees of the decertification and the enrollees have had the opportunity to enroll in other coverage. Coverage under the decertified plan should continue until the effective date of coverage under another QHP, (following a special enrollment period, if necessary). Once an Exchange determines that a plan will be decertified, the notification process for enrollees should happen as swiftly as possible to avoid enrollees remaining in a decertified plan for any longer than is necessary.

Recommendation: Enrollees transitioning out of a decertified plan should experience no gaps in coverage. Coverage under the decertified plan should continue until the effective date of coverage under another QHP (following a special enrollment period, if necessary).

We thank you for the opportunity to submit our comments and urge you to consider our suggestions in order to enable Exchanges to best serve individuals, families, and small businesses. If you have any questions, please feel free to contact Claire McAndrew by email at cmcandrew@familiesusa.org or by phone at 202-628-3030. Families USA looks forward to working with HHS as the federal government and states implement Exchanges in the coming years.

Sincerely,

Claire McAndrew
Senior Health Policy Analyst
Families USA

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[1] Office of Management and Budget, "Revision to Office of Management and Budget Circular No. A-76, 'Performance of Commercial Activities.'" *Federal Register* 68, no. 103 (May 29, 2003): 32134.
[2] National Academy of Social Insurance, *Designing an Exchange: A Toolkit for State Policymakers* (Washington: National Academy of Social Insurance, January 2011).
[3] Massachusetts General Laws, Chapter 58 of the Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care, April 12, 2006*, available online at http://www.malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58.
[4] 2011 Laws of Maryland, Chapter 2, *Maryland Health Benefit Exchange Act of 2011*, available online at http://www.dhmh.state.md.us/healthreform/Exchange/pdf/MHBEA_Enrolled.pdf.
[5] National Association of Insurance Commissioners, Compendium of State Laws on Insurance Topics, "Producer Licensing Fees" and "Producer Education and Examination Requirements" (Kansas City, MO: NAIC, 2010).
[6] For example, to sell health insurance in Texas, an agent must have a general life, accident, health, and HMO license. The exam for this license covers the following insurance products: health, life, annuities, disability income,

dental, Medicare supplements, and long-term care. Prometric, Texas Department of Insurance Licensing Information Bulletin for Examinations on and after February 1, 2011, pp. 20-21, available online at www.prometric.com/NR/rdonlyres/einkbot3uirw5sd3zcc3fhpy4rtilt2ojp52ogisrlmeujefnmavnrkfrc5sznrehzeddhvv5hvxgccc5e7mzrtqyuf/TXINSLIB20110201FINAL.pdf.

[7] National Association of Insurance Commissioners, op. cit.

[8] Health Assistance Partnership, *State of the SHIPS: A Summary of Results of the 2009 SHIPS Needs Assessment Survey* (Washington: Families USA, January 2010), available online at http://www.hapnetwork.org/assets/pdfs/state-of-the-ships-report/2010.pdf. Methods of certification are described at http://www.hapnetwork.org/shipcertification/methods.html.

[9] Healthy Families Program, *Enrollment Entity and Certified Application Assistant Forms*, (Sacramento: State of California, 2011), available online at: http://www.healthyfamilies.ca.gov/EEs_CAAs/Forms.aspx#CAA_Agreement.

[10] Henry J. Kaiser Family Foundation, *A Profile of Health Insurance Exchange Enrollees*, (Washington: KFF, March, 2011).

[11] Webinar, *"Consumer Voices: What Motivates Families to Enroll in Coverage?"* (Washington: Robert Wood Johnson Foundation, GMMB, and Lake Research Partners, September 14, 2010), available online at http://www.insurekidsnow.gov/professionals/outreach/webinars/challenging_times_motivate_families_slides.pdf.

[12] Webinar, "Consumer Voices: What Motivates Families to Enroll in Coverage?" (Washington: Robert Wood Johnson Foundation, GMMB, and Lake Research Partners, September 14, 2010), available online at http://www.insurekidsnow.gov/professionals/outreach/webinars/challenging_times_motivate_families_slides.pdf.

[13] The Free Dictionary, http://www.thefreedictionary.com/price+control.

[14] § 1311(e)(2)

[15] See, for example, Medicare Rights Center, "Too Good to Be True: The Fine Print in Medicare Private Health Plan Benefits," April 2007; Brian Biles, Lauren Hersch Nicholas and Stuart Guterman, "Medicare Beneficiary Out-of-Pocket Costs: Are Medicare Advantage Plans a Better Deal?" The Commonwealth Fund, May 2006; and Government Accountability Office, "Medicare Advantage: Increased Spending Relative to Medicare Fee-for-Service May Not Always Reduce Beneficiary Out-of-Pocket Costs," February 2008.

[16] This section is developed in large part based on standards CMS uses for monitoring the marketing practices of Medicare Advantage plans. For more information see, Government Accountability Office, "Medicare Advantage: CMS Assists Beneficiaries Affected by Inappropriate Marketing but Has Limited Data on Scope of Issue," December 2009.