October 24, 2011

Centers for Medicaid and Medicare Services
Department of Health and Human Services
Attn: CMS-9989-P
P.O. Box 8010
Baltimore, MD 21244-8010

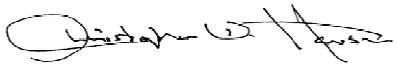
To whom it may concern:

The American Cancer Society Cancer Action Network ("ACS CAN") is the advocacy affiliate of the American Cancer Society (the "Society"). The Society is a nationwide, community-based, voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy, and service. The American Cancer Society, operating through its national office and 13 chartered, geographic division affiliates throughout the United States is the largest voluntary health organization in the United States.

ACS CAN appreciates the opportunity to provide comments to the U.S. Department of Department of Health and Human Services on Proposed Rule for the Establishment of Exchanges and Qualified Health Plans published in the Federal Register on July 15, 2011. .

ACS CAN offers the attached comments for your consideration.

Sincerely,



Christopher W. Hansen
President

Attachment

Part 155, Subpart B – General Standards Related to the Establishment of an Exchange by a State

§155.105 Approval of a State Exchange

We appreciate the emphasis HHS has placed on ensuring that all states will have insurance exchanges operating in time to provide coverage to individuals and small businesses beginning on January 1, 2014. We agree that in order to meet this deadline, an Exchange must be capable of beginning operations to support the initial open enrollment period set to begin on October 1, 2013 and to meet certain standards and be able to perform the required functions.

Approval Standards, §155.105(b)

The rule proposes the basic standards that HHS will use to determine whether a state Exchange is fully operational, and we agree that these, at a minimum, are needed to ensure that an Exchange functions well. As the rule proposes, the state Exchange must be able to carry out the functions in subparts C, E, H, and K; agree to perform the responsibilities related to operation of a reinsurance program; and be capable of carrying out the information requirements related to the premium credits for low- and moderate-income participants in an individual exchange. We are particularly pleased to see that the rule makes the information requirements related to the premium credits an approval standard for states seeking to operate an Exchange. We believe this is an essential element to ensure the premium subsidies can be administered properly.

The rule proposes that, in order for a state to be approved to operate an exchange, the entire geographic area of the state be covered "by one or more exchanges." In accordance with the statute each Exchange in a state must operate in geographically distinct areas and no area should be served by more than one exchange. This is necessary to reduce confusion among 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 where there are multiple exchanges, each Exchange serves 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, as added by section 1201 of the Affordable Care Act.

As part of ensuring that state exchanges meet the approval standards on an ongoing basis, HHS should establish a process to accept consumer complaints about the functioning, operations, or policies of a state Exchange at the federal level. The process should ensure that HHS appropriately reviews consumer complaints and works with states to correct them. To the extent that a state does not appropriately respond to HHS attempts to resolve issues reported by consumers, enforcement actions would be necessary. We have recommended in comments on §155.106(b), Transition process for State Exchanges that Cease Operations, that HHS establish interim enforcement mechanisms that would be less extreme than cutting off a state's Medicaid or premium tax credit funding or replacing a

state Exchange with one operated by the federal government. Such interim enforcement measures (or the more extreme mechanisms, when the situation warrants) would be appropriate for HHS to consider in situations of unresolved consumer complaints. As part of establishing a process to address consumer complaints about a state exchange, HHS should ensure that consumers are aware of the ability to make complaints to the federal government.

Recommendations: 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." Establish a process for HHS to accept, review, and work with states to correct consumer complaints related to the operations, functions, or policies of a state exchange. Establish interim enforcement mechanisms that HHS can use in instances when a state or state Exchange is not responding appropriately to correct issues raised through consumer complaints.

Approval Process, §155.105(c)

We support the proposal to create an approval process of state Exchange Plans that is modeled on the state plan process used for Medicaid and the Children's Health Insurance Program. This is needed so that HHS can review the details of how a state is approaching the operation of its Exchange, assess whether the state Exchange meets the standards in federal law, and serves consumers well. Some parties commenting on the proposed rule may argue that the state plan process suggested by HHS will be overly cumbersome or time-consuming for states. In response, we would point out that the federal government has an obligation to enforce the requirements established by the Affordable Care Act and must have a mechanism to ensure that states are acting in accordance with federal standards. In addition, many if not most of the participants in a state's individual-market Exchange will be receiving premium credits and cost-sharing reductions that are fully funded by the federal government. In SHOP exchanges, federal tax credits will be available to small businesses meeting certain criteria. It is imperative for HHS to ensure that federal funds are being spent appropriately and that Exchange participants are receiving the benefits and assistance required by law. The Exchange Plan process will help HHS fulfill these obligations, both as it initially approves state Exchanges and as states modify their Exchanges over time.

The public must also have the opportunity to review and comment on a state's Exchange plan. We appreciate that states are required to seek stakeholder input during the process of planning for an Exchange. But the public, especially the consumers who will utilize the exchange, must have the opportunity to review a state's final policy and operational decisions and to comment on them before they are implemented. Therefore, HHS should ensure that states' Exchange Plans are made publicly available and 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 approved. We believe this could be done

within the 90-day timeline for HHS approval or denial of an Exchange Plan that the rule proposes.

We support the proposal to coordinate the readiness assessment of exchanges with the assessment process being used in the monitoring process for Exchange Planning and Implementation Grants. Through this process, HHS has identified core areas and milestones for states that we believe address the major elements needed to ensure Exchanges are ready to operate.

Recommendation: Ensure that states' Exchange Plans are publicly available and subject to a comment period prior to approval.

Exchange Approval, §155.105(d)

We recognize that the concept of conditional approval is intended to ensure that as many states as possible are ready to operate by January 1, 2014. We agree that in certain limited cases it is appropriate for a state that is close to being fully operational on January 1, 2013 to be granted a conditional approval, as the rule proposes, even if a state has additional tasks to complete in 2013. But more detail is needed to ensure that conditional approval is available only in limited instances, does not result in states missing the 2014 deadlines, and does not impede the federal government's ability to prepare to operate an Exchange if a state will not be ready to do so on time.

The preamble to the proposed rule suggests that a state could receive conditional approval to operate an Exchange even as "systems development and contracting activities" continue to occur in 2013, after the statutory deadline for approval of a state Exchange. In our view, it may be reasonable to allow a state to finish testing its IT systems in 2013, for example, but this would have to be done sufficiently ahead of the open enrollment period to allow any needed adjustments to be made. It also may be reasonable for an Exchange to finalize contracts with qualified health plans in 2013, but, again, this process would need to be finished very early in the year, to give the Exchange and approved insurers time to conduct consumer outreach and marketing activities prior to the beginning of the initial open enrollment period.

The most concerning scenario would be one where a state appears in January 2013 to be on track to meet the January 1, 2014 deadline. Based on this, HHS could grant the state conditional approval, but then problems could arise in the remaining tasks the state Exchange needs to complete during 2013. At what point during 2013 would HHS prepare to operate a federally facilitated Exchange in such a situation? How much time in advance of October 2013 would HHS require to have a fully operational federally facilitated exchange? We recommend that HHS, in granting conditional approval to a state, also establish interim deadlines during 2013 that would assure that an Exchange — whether operated by the federal government or by the state — is fully operational by the start of the initial open enrollment period. The interim deadlines could be specific to a state's remaining tasks (for example, three additional months or until April 1, 2013, to complete

contracting with health plans). Or there could be a "drop dead" date, perhaps in the mid part of 2013, at which time HHS would start to implement a federally facilitated Exchange in a state that is not fully ready.

Recommendation: Establish interim deadlines during 2013 for states that receive conditional approval to operate an Exchange, such that remaining tasks are completed far enough in advance of the first open enrollment period.

Significant Changes, §155.105(e)

We believe that an Exchange Plan process modeled on the one used for Medicaid and CHIP can operate in a streamlined manner, so that states have the ability to modify Exchange operations promptly, for example in response to insurance-market conditions and problems that arise for consumers.

We recommend that the final rule or future guidance more clearly define what qualifies as a "significant change" to a state's Exchange Plan. We propose a standard 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, such that changes to the content of the Exchange plan would constitute a "significant change," while changes not affecting the Plan would not. As the preamble notes, such significant changes could include (but are certainly not limited to) changes to governance structure, state laws or regulations, IT systems or functionality, the QHP certification process and the enrollment procedures. We further recommend that "significant changes" to an Exchange Plan be subject to transparent public notification and comment, modeled on the processes that exist for Medicaid.

Recommendations: Clearly define what amounts to a significant change to a state's Exchange plan, and ensure that significant changes are subject to public notice and comment.

HHS Operation of an Exchange, §155.105(f)

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 the proposed rule sets out 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 would work. With state-operated Exchanges, the proposed rule leaves many decisions about how to carry out specific requirements open and subject to state discretion. Therefore it is difficult to determine how a federally operated Exchange might meet these requirements and whether decisions about such details would differ from state to state or be consistent in all places where a federally facilitated Exchange operates. As states weigh whether to operate their own exchanges, it is essential that they have sufficient information about how the federally operated exchange, the alternative, would work. In addition, 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 inform the public — particularly residents of the state where it will operate — about the final decisions it makes regarding how it will carry out the minimum functions. A federally facilitated Exchange should ensure that a document, much like an Exchange Plan for state-operated exchanges is created and shared with the public.

Recommendations: Address in the final rule the details of how a federally facilitated Exchange would work, particularly whether such an Exchange would differ in some respects from state to state and how a federally developed and operated Exchange would meet the necessary standards. Establish a process for a federally facilitated Exchange to document how it will carry out the necessary functions, any significant changes made by the Exchange over time, and ensure the federal exchange's planning document and updates are exposed to public notice and comment.

Partnership Model

We understand the need for state flexibility and applaud HHS for seeking creative ways for the federal and state governments to develop nascent organizations into robust Exchanges. Much needs to be learned by all parties, and it makes sense to take the most advantage of the relative strengths and expertise among the states and the federal government. However, we believe strongly that any such partnerships must have the consumer's interests at their core. To accomplish this will require a clear delineation of responsibilities between the federal and state governments and the development of strong consumer protections to ensure continued access to care while the federal and state governments resolve any disputes.

With the partnership concept, HHS appears to be contemplating a continuum of state-federal relationships that might exist for development and leadership of an Exchange. At one end of the continuum is an Exchange that is operated fully by the state, and at the other end is an Exchange fully operated by the federal government. In between there is a continuum of potential arrangements between HHS and the states. Under the ACA, any state that fails to have its Exchange certified (by performing all of the required functions outlined in the proposed rule) will have a federal Exchange, and the federal government will have ultimate decision-making authority and accountability. It may be possible, through the partnership approach, for some functions to be administered by the state as a partner in the federally operated Exchange. However, the permutations of such partnerships must be limited and clearly delineated in the final regulation.

If a partnership model for Exchanges is permitted, it should be done consistent with the following principles:

- *The ultimate decision-making authority and responsibility for core functions of an Exchange must be within the purview of a single governing board or entity* (as defined in the section 1311 of the ACA and the Exchange NPRM Part 155, subparts C, E, H and K, and subpart 156, subpart C). Section 1321 of the ACA requires either the state or the federal government to "establish and operate" an Exchange in a state. Either can contract out functions, but only one entity can be ultimately responsible for operation of an Exchange. The final regulation should make clear that a partnership model, if utilized, would adhere to this requirement. For example, in a State with a federal Exchange even in partnerships with states, the federal government will exercise the decision-making and responsibility for the core functions. Furthermore, the final regulation should clearly state that any functions performed by the state in partnership with a federal Exchange are subject to federal law and regulations for purposes including but not limited to open books and records requirements.

- *Increasing efficiency and reducing redundancy are appropriate and highly desirable goals for successful Exchange implementation, and the best way to realize these goals is to look for partnerships that advance common administrative and business operations and best practices.* We support the statement in the Preamble of the proposed rule that this could be an advantageous type of partnership. We also agree with the Preamble's statement that partnership efforts or other forms of collaboration should help to reduce redundancy, promote efficiency, and help states meet implementation timeframes.

Not all Exchange functions are appropriate for the Partnership approach. Creating silos or dividing core Exchange functions between a state and the federal government could hamper coordination, negatively impact consumers and small businesses, and undermine the efficiency and success of an Exchange. The functions where the states are permitted to partner must not be integral to the basic operations of the Exchange, lest poor performance by the state undermine the overall viability of the Exchange. The core function areas where we believe a partnership would be appropriate and viable are the Navigator and Consumer Assistance Programs. It may be workable for a federally facilitated Exchange to rely on a state to develop (or help develop) these programs because the state may be well-positioned to do so on behalf of its residents.

- *One overarching goal of an Exchange is to provide a seamless, one-stop shop for the consumer regardless of who actually operates it, and this goal does not change for Exchanges operated under a partnership approach.* Consumers must be able to obtain eligibility determinations for the appropriate coverage program (whether Medicaid, Exchange premium tax credits and cost-sharing reductions, Basic Health, or other programs), to obtain comparative information on health plans, and enroll in a health plan in a single visit to the Exchange, whether in person, by telephone or on-line. We see serious potential problems if states are able to leave the eligibility and enrollment functions of the Exchange to the

federal government under the partnership approach. The state would continue to determine eligibility for its Medicaid program for those not eligible to enroll at the exchange and for others who seek coverage directly at the state, and it is likely that people moving between Medicaid and the Exchange would experience difficulties or gaps in coverage if a different entity (the federal government) were to be in charge of eligibility determinations for those seeking coverage at the Exchange. Such gaps and difficulties would violate the requirement that eligibility be seamless and coordinated between the Exchange and Medicaid. Thus, if HHS decides to operate the eligibility and enrollment functions of the Exchange while states perform other Exchange functions, HHS must ensure this separation is entirely invisible to and seamless for the consumer. We think this would be extremely difficult, but if it is allowed the state must explicitly agree that it will take all necessary actions to work with the HHS to ensure a seamless system, including accepting eligibility determinations for Medicaid made by the federal government

- *Whenever functions are contracted out, it is essential that an Exchange operated under a Partnership remains accountable for compliance with the ACA and for the performance of its contractors and that this responsibility includes monitoring, oversight and enforcement of the contractual obligations.* The ACA and the proposed rule authorize Exchanges to contract out responsibilities of the Exchange with (1) entities incorporated under and subject to the laws of one or more states, that have demonstrated experience in health insurance markets and coverage, and that are not health insurance issuers or treated as health insurance issuers, and (2) the state Medicaid agency. Some functions of the Exchange should not be contracted out to a non-governmental third party because they are inherently governmental. These include eligibility determination for Medicaid and the premium tax credits for QHPs, as well as appeals processes for eligibility determinations.

- *The Department needs to develop more specific levers to protect consumers if there is a dispute between the federal government and the state about Medicaid eligibility.* If a state does opt for the federal Exchange, the proposed Medicaid rule would require a state to accept the determination of Medicaid or CHIP eligibility made by the federal Exchange. But the department needs to more directly address how to manage the relationship between states so as to minimize the burden on consumers.

We are concerned about the proposal allowing states to control plan management functions in a federal-state partnership. This proposal fails to meet a number of the above principles. First, it potentially splits the ultimate authority for a critical set of core functions between the federal and state governments. As a result, the necessary feedback loops between enrollment processes and consumer experience in plans will be missing or severely short-circuited. Second, it is not a function appropriate for the partnership. States may knowingly or unknowingly undermine the viability of the exchange through poor plan

choice or lack of enforcement of rules regarding plan activities. It could create circumstances where the state may contribute to adverse selection against the exchange by favoring certain plans (and how it operates the market outside the exchange). Finally, such a division of core functions may also impede the seamless nature of the Exchange. While states will oversee plan activity, the federal government will be responsible for related services including consumer appeals and complaints and eligibility determinations..
Recommendations: Ensure through regulation that possible versions of the the partnership approach are clearly defined. Clarify that an exchange operated using the Partnership model is federally operated, that the federal government has decision making authority over and accountability for it, and that any functions a state performs for a federally operated Exchange are subject to federal law and requirements, including but not limited to open books and records requirements. Consider ways that states and the federal government could partner on development of Exchange business functions. Clarify through regulation that certain functions of an Exchange are not appropriate for a Partnership, such as eligibility and enrollment functions. Set standards to ensure that any Partnership that is allowed meets the goals of increasing efficiency, reducing redundancy, and providing consumers with a seamless, one-stop shop for the consumer. Clarify that an Exchange operated under a Partnership remains responsible for the performance of its contractors and their compliance with applicable requirements. Develop specific levers to protect consumers if there is a dispute between the federal government and a state about Medicaid eligibility.

§155.106 Election to Operate an Exchange after 2014

It is essential to establish a process for states to elect to operate an Exchange after 2014, and also to ensure a process is in place if a state operating an Exchange wants to transition to a federally facilitated exchange. The key goals for both of these processes should be ensuring as smooth a transition as possible and minimizing disruptions for individuals and small businesses that will participate in the insurance exchanges.

Election to operate an Exchange after 2014, §155.106(a)

The proposed rule appropriately ensures that, in order for a state to be approved to operate an Exchange after 2014, it must meet all of the same standards and criteria set out in §155.105, including submitting an Exchange Plan and undergoing an operational readiness assessment by HHS. We agree with the proposed rule's requirement that HHS' approval or conditional approval of a state Exchange be secured at least 12 months prior to the first effective date of coverage through the exchange. This will ensure that there is ample time for a transition process ahead of the next open enrollment period, when consumers may have to familiarize themselves with different coverage options and modified Web sites or other consumer assistance resources.

A state that takes over operations of an Exchange should have to demonstrate (either as part of its Exchange plan or the transition plan worked out with HHS) how it will address

any particular issues related to informing or educating consumers about the changes that will from the transition. Ideally, changes to consumers' use of the Exchange could be minimized (for example by ensuring that consumers are automatically redirected from an old Web site to a new one, or that call center numbers remain the same). But to the extent this is not possible, the state should ensure that appropriate protections are in place. In particular, any transition of consumers to new plans, especially if the plans differ in regard to covered benefits, will require special attention.

While we believe that all exchanges should be certified at the same minimum level, states electing to take over from a federal Exchange should not be allowed to weaken the already established Exchange. Consumers should have guaranteed access to health plans at similar or better levels of affordability, adequacy and administrative simplicity. Additional certification criteria and future measurement standards should be in place to ensure that the new state-run Exchange can expect similar or better insured rates, quality of coverage and affordability rates. Such criteria may be similar to that expected of states pursuing waivers including requirements for actuarial value studies, etc.

Recommendation: Require a state electing to operate an Exchange after 2014 to address (either in the Exchange plan or as part of the transition plan established with HHS) how it will address changes that may impact consumers or Exchange operations. Ensure that consumers in states electing to run an Exchange after 2014 have access to health plans at similar or better rates of affordability, adequacy and administrative simplicity than were available in the federal Exchange and that there is no lessening of the quality of services or products available as a result of a transition to a state run exchange.

Transition process for State Exchanges that cease operations, §155.106(b)

It is reasonable to require a state that wishes to stop operating an Exchange to provide HHS with sufficient notice to transition the enrollees of the state Exchange to a federally facilitated Exchange that will make coverage available and otherwise fulfill the necessary requirements. The proposed rule states that HHS needs at least 12 months to make the needed preparations, and we support requiring states to give the federal government at least this amount of lead time. We also support requiring states to coordinate with HHS on a transition plan.

We are concerned, however, about how these requirements would be enforced. Some states that want to stop operating an Exchange may not coordinate with HHS on a smooth transition to a federally operated exchange. Or there may be instances when a state decides to cease operations of an Exchange more quickly than the 12 months that HHS has proposed. This could seriously disrupt consumers' coverage. We urge HHS to specifically address how the requirements at §155.106 could be enforced, so that states understand the consequences of failing to meet their obligations. While such extreme options as withholding subsidies or Medicaid funding may be available to HHS, these options are unlikely to be used and if used, may cause significant harm to consumers. We urge HHS to

develop interim enforcement mechanisms. One possibility would be a corrective action plan process, under which a transition to a federal Exchange would occur only if the corrective action plan is not successful. In addition, HHS should make back-up plans for those states that do not or are unable to provide a 12-month advance notice. This should clearly provide HHS the authority to act immediately if the state Exchange ceases to function, regardless of the reason. HHS' back-up plans should seek to minimize problems for consumers, especially gaps in coverage, which can occur when a state ceases operating an Exchange without following the established procedures. For example, HHS could arrange for consumers to remain with their existing qualified health plans, at least on an interim basis, despite the fact that the Exchange that certified those plans is not operating.

The proposed rule also does not specifically address the process for transitioning from a state-operated to a federally facilitated Exchange when the state Exchange is not complying with federal requirements and standards. This is another case where a backup plan for quickly providing at least interim coverage to consumers would be important, since states in this scenario may not cooperate on a transition plan and HHS may have fewer than 12 months to establish a federally facilitated exchange.

Recommendations: HHS should address how it will enforce the requirement for states ceasing operation of an Exchange to provide sufficient notice to HHS and to coordinate with HHS in order to make a smooth transition. HHS should develop a range of options for enforcement, including interim options like corrective action plans, that are less extreme than withholding subsidy or Medicaid funding. In addition, HHS should establish a process for transitioning to a federally facilitated Exchange in cases when a state-operated Exchange is determined to be non-compliant with the requirements for insurance exchanges or Exchange coverage. HHS should establish backup processes to ensure that adequate coverage (through qualified health plans or other programs) is available to consumers if a state ceases operation of its Exchange without giving 12 months notice to HHS or collaborating on a transition plan.

§155.110 Issues related to Contracting

§155.110 Entities eligible to carry out Exchange functions

Some states will delegate specific Exchange functions to outside contractors; however, the Exchange must remain accountable for meeting all federal and state requirements. There should be limits to the functions that can be contracted to outside parties and contracting entities should be required to meet conflict of interest and confidentiality standards. We support the inclusion of Medicaid as an eligible contracting entity.

§155.110(a)

HHS seeks comment on functions that web-based outside entities could perform. The functions they could perform should not include any of the functions listed above as "inherently governmental." In particular, HHS notes the requirement that "advance payments of the premium tax credit and cost-sharing reductions may only be accessed

through an Exchange." Whatever functions a web-based entity might ultimately perform for a state, it is clear that delivery of subsidies is not one of them, and HHS should continue to make this clear.

For functions that are not inherently governmental, the potential promotional gains in linking the Exchange to established web-based entities should be weighed against likely consumer confusion about which website is the "right" venue for the purchase of insurance that will be eligible for a tax subsidy, the extra costs associated with such a vendor, and the potential for mismanagement of consumers' personal information. For example, a web-based entity could use the personal information collected to steer healthy individuals to plans outside of the Exchange. As with any contractor, conflicts of interest should be disclosed. This is not just a theoretical concern. In California and likely other states, the website ehealthinsurance.com — a licensed health insurance broker — is noting its interest in helping to operate Exchanges.

We support the inclusion of Medicaid as an eligible contracting entity.

§155.110(b)

Section 1313(a)(5) of the Affordable Care Act directs that "the Secretary will provide for the efficient and nondiscriminatory administration of Exchange activities…" This provides a clear basis, and signals strong intent, for the Secretary to ensure that states use governmental staff to perform critical Exchange functions and prohibit states from privatizing inherently governmental functions.

Moreover, many functions of the Exchange are "inherently governmental," as defined in OMB Circular No. A-76 (revised 2003).[1] One of the purposes is "to make agencies accountable to taxpayers for results achieved…." 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."

Applying these principles to the Exchanges, HHS should determine the following activities to be "inherently governmental" and not eligible for contracting to a non-governmental entity:

- Establishing standards for qualified health plans offered in the Exchange (and ensuring these standards are consistent with section 1557 of the Act);
- Negotiating with or selecting plans to participate in the Exchange;

[1] Revision to the Office of Management and Budget Circular NO. A-76, "Performance of commercial Activities." Federal Register, Vol 68, No. 103, May 29, 2003, p. 32134.

- Certifying and decertifying plans to be offered in the Exchange, including the ability to exclude plans if it is in the interests of individuals and employers in the state or if a plan proposes unjustified premium increases;
- Regulating the practices of insurance plans in the Exchange including monitoring marketing practices, ensuring that benefits are not designed to cherry pick healthier enrollees, ensuring adequate choice of providers, monitoring the handling of consumer complaints;
- Administering risk adjustment mechanisms among participating insurers;
- Determining whether individuals qualify for the federal premium tax credit and the cost-sharing reductions and if they do not, screening and enrolling them for eligibility for public programs like Medicaid;
- Establishing and administering an appeals process for individuals denied eligibility for the tax credit;
- Determining hardship exemptions for individuals and employers from the requirement to purchase health insurance or face a penalty;
- Determining penalties for employers who drop or don't provide health care for their employees and who obtain premium tax credits through the Exchange;
- Establishing and administering an appeals process for employers challenging penalties;
- Establishing policies and procedures for verification of Social Security numbers, tax credit eligibility and immigration status with federal agencies;
- Resolving inconsistencies with information as reported by the Social Security Administration, Department of the Treasury or Department of Homeland Security;
- Handling and transmitting a variety of confidential information including federal income tax return data, income and other information included in Medicaid applications, and Social Security Administration data;
- Establishing eligibility criteria, selecting and overseeing the Navigator program; and
- Assessing fees to participating health insurers or to otherwise fund the ongoing operation of the Exchange.

Because of how the decisions that are made in these areas will determine, for example, whether low- and moderate-income individuals and families obtain the premium tax credits and cost-sharing reductions to which they are eligible and thus whether they can obtain health coverage, it is essential for strong public accountability for how these functions are performed. Whether they are performed well or poorly would not only affect small businesses, individuals and families, but also taxpayers who would be on the hook if costs are higher than they otherwise would be. We believe that the best way to ensure accountability is through the use of governmental staff who will carry out these functions without bias and conflicts of interest and in the best interest of the public. The 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.

While it may be appropriate to delegate some functions of the Exchange to a private contractor, such as designing IT programs, many functions of the Exchange must be performed by governmental staff that are accountable to the public. In particular,

mechanical functions such as data processing and other IT requirements, as well as billing, collection and payment reconciliation of premiums that should be considered for private sector contracting where competitive markets exist and for which performance can be readily monitored.

HHS indicates that Exchanges should include "copies of any agreements into which the Exchange has entered" to carry out Exchange functions. (p.41871) Sharing copies of agreements only after they have been signed may prove to be problematic. There are numerous examples of states ill-advisedly entering into expensive contracts with poor results and at a waste of taxpayer money due to the state's inexperience, inattention, or overriding political decisions in contracting. For example, both Texas and Indiana ran into severe problems when they retained commercial vendors to transition to new IT systems for Medicaid and Food Stamps; California automated its Child Support Enforcement system at great expense only to find that it was not interoperable with the states' other systems.

Recommendations:
Reference OMB Circular No. A-76 (revised 2003) as model guidance to states indicating what functions government should perform and what may be contracted out under the supervision of a government entity.

Retain the expectation in §155.110(b) that the Exchange remains responsible for ensuring that all contracted functions are met. Add conflict of interest and privacy provisions to ensure that the Exchange, HHS and the public know of a vendor's potential financial conflicts and to protect the personal data of consumers.

HHS should require that Exchanges submit to HHS for approval contracts in excess of $5 million ($1 million in the case of noncompetitive acquisitions), similar to the requirement for approval of SNAP Automated Data Processing contracts. For smaller contracts, HHS should encourage states to share potential contract language in advance as part of its ongoing communication process.

§155.110 Entities eligible to carry out Exchange functions

Entities eligible to carry out Exchange Functions §155.110(a) and (b)

We support the requirement that, in the event an Exchange enters into an agreement with an eligible entity to carry out one or more functions of an Exchange, the Exchange remains the principle entity responsible for ensuring that all federal requirements are met. Furthermore, certain exchange functions are inherently governmental and thus must be performed by public entities.

While we recognize the possible benefit or need for an Exchange to seek such agreements with eligible entities – particularly the state Medicaid agency for the purposes of eligibility and enrollment – we are concerned that certain functions may not be appropriate or eligible for outsourcing to a third party, non-governmental entity. Specifically, the process of making determinations of an individual's eligibility for Medicaid, CHIP, federally funded premium tax-

credits or cost-sharing reductions should not be contracted out to private entities nor should the appeals process for eligibility determination be contracted out. Additionally while some aspects of grievances and appeals of other issues could possibly be handled by a third party, the consumer should always have recourse via a process that is directly overseen by the Exchange.

Recommendation: The final rule should clarify that certain functions of an exchange may not be contracted out to a non-governmental entity, particularly the determination of individuals' eligibility for Medicaid, federally subsidized QHPs, or other coverage programs.

Entities eligible to carry out Exchange Functions §155.110(c)

It is critical that CMS establish minimum requirements for all exchange governing boards. In particular, we support the requirement that any such governing bodies must be administered under a publicly adopted charter or bylaws and must hold regular public meetings with advanced notice provided to the public. Additional requirements to ensure transparency, openness, and fair practices are welcome as well.

We strongly recommend that HHS require that all exchange governing boards prohibit membership of individuals that possess a clear conflict of interest. It is detrimental to the goal of the exchange – to provide affordable health coverage to millions – and to taxpayers supporting premium tax credits if exchange boards are comprised of parties that have a financial interest in increasing the cost of health insurance. Individuals with a clear conflict of interest should be explicitly defined in regulations as individuals affiliated with health insurance issuers, insurance agents or brokers, health care providers or health care facilities. Additionally, this prohibition should explicitly extend to individuals affiliated with an entity whose primary line of business serves or whose clientele is largely comprised of individuals or organizations identified above as conflicted parties, such as major vendors, subcontractors, or other financial partners.

We believe that HHS should clearly define representatives of consumer interests. Such a definition should include: individuals who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the individual exchange; small business employees who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the SHOP exchange; and non-profit organizations that represent or advocate on behalf of the individuals in the categories mentioned above. Additionally, for purposes of board membership, HHS should separately define representatives of small employers as small business owners who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the SHOP exchange. HHS should perhaps include language in the regulations that permit this definition to be adjusted once a state permits larger employers to enter the SHOP.

If HHS intends, as stated in the preamble and in §155.110(c)(3), to ensure that exchange governing boards predominantly represent consumer interests, then the final rule must be more explicit on this issue. Specifically, if HHS ultimately will permit conflicted parties to serve on exchange boards, there should be more representatives of consumer interests (as defined above) than conflicted voting members and consumer interests should constitute an overall majority and

a voting majority of the board. A precedent for such a requirement exists in 42 USCS § 254b(k)(3)(H) regarding requirements of governing boards for Federally Qualified Health Centers (FQHCs), where a majority of the board must be individuals being served by the health center.

Prohibiting – or at least limiting – representation from conflicted parties is crucial to the success of exchanges. Health insurers have a direct financial interest in the outcome of exchange policy decisions. While it has been proposed in certain states that board members must recuse themselves in instances of conflict, we believe that *all* exchange governing board decisions would pose a conflict for insurers. As such, health insurers would be unable to serve on a governing board in any meaningful capacity. While we recognize the specific expertise and knowledge representatives of insurers may provide, such expertise can and should be harnessed through other formal, non-governing channels, such as a robust stakeholder consultation process. Brokers and agents, too, could be conflicted, particularly in states where it is customary for insurers to pay brokers a percentage of the insurance premium. Health care facilities and practicing, individual health care providers, also have significant conflicts of interest. Any conflict of interest permitted in exchange governance has the potential to result in decisions that disproportionately benefit these financially conflicted parties, likely at an increased cost to states, the federal government, and the consumer.

In addition to direct financial conflicts, a role in governance may give insurers the opportunity to set policies to the detriment of consumers. For example, if a state's dominant insurer is on the exchange governing board, it may block initiatives meant to increase insurance competition by bringing in new market entrants. In this manner, including insurers and other conflicted parties onto the exchange board may reduce the potential for exchanges to achieve a truly competitive and successful marketplace.

If insurers and other conflicted parties are permitted on a governing board in certain states, HHS must ensure provisions to mitigate such financial conflict and potential adverse impact on consumers. One important step, as outlined above, is to limit insurer representation to equal to or less than the number of members representing consumer interests.

We also strongly recommend that HHS be more explicit in the standards exchanges must meet in terms of policies on ethical practices and conflict of interest. Specifically, HHS should set a minimum benchmark standard for exchanges requiring board members and staff to:

- Disclose any affiliations (financial or otherwise) that may cause the appearance or presence of a conflict of interest with their role in an exchange;
- recuse themselves from all discussion and votes associated with such conflict;
- refrain from accepting any gifts (or any gifts exceeding a reasonable limit) from any individual or entity that can be considered a conflicted party; and
- report any potential unethical action or transgression on behalf of themselves, staff, board members, or vendors.

Recommendations: The final rule should require all exchange governing boards to prohibit membership of individuals that possess a clear conflict of interest. Conflicted parties

should be defined as individuals affiliated with health insurance issuers, insurance agents or brokers, health care providers or health care facilities. Individuals should also be considered conflicted if they (or an entity they are affiliated with) has as a primary line of business the service of conflicted parties or a clientele largely comprised of conflicted parties. The final rule should clearly define representatives of consumer interests.

If the final rule permits conflicted parties to serve on exchange boards, consumer interests (as defined above) should constitute an overall majority and a voting majority of the board. HHS must also provide explicit standards for exchanges to meet regarding ethical practices and conflicts of interest, including by barring conflicted parties from participating in votes on or discussions about issues on which they are conflicted.

SHOP Independence Governance, §155.110 (e)

We strongly support the preamble statement that a single governance structure for both the individual market Exchange functions and SHOP will produce better policy coordination, increased operational efficiencies and improved operational coordination. It would also avoid duplication of key Exchange functions including certification of qualified health plans, eliminate the need for duplicative information collection and reporting, and ensure more seamless coverage for individuals (who may be going back and forth between SHOP coverage through their jobs and individually purchased coverage that may be subsidized by premium tax-credits and cost-sharing reductions).

We therefore strongly disagree with the proposed rules at §155.110 (e) that permit a State to elect to create an independent governance and administrative structure. There is nothing at all in section 1311(b) of the Affordable Care Act that explicitly permits states to have a separate structure. The preamble, however, states that because states can provide a single exchange for both individuals and small businesses that this means that States can operate their individual and SHOP exchanges entirely separately. This reading is inconsistent with the statute. Section 1311(b)(1) states that each State must establish *an* American Health Benefit Exchange that among other purposes and functions, provides for the establishment of a Small Business Health Options program (SHOP) under section 1311(b)(1)(B) of the Affordable Care Act. This seems to imply a State is required to establish a single administrative and operational structure with one of the structure's duties to to administer and operate a SHOP exchange for small businesses). Moreover, nothing in section 1311(b)(2) discusses governance or administrative structure but rather about the option for States to use a single Exchange for both individual and small businesses to provide "Exchange" *services* such as offering QHPs..

Recommendations: §155.110(e)(1) should be struck and §155.110 (e)(2) should be renumbered accordingly. It should also be amended to delete any reference to governance or administrative structure and instead codify the actual language of section 1311(b)(2) of the Affordable Care Act to read as follows: "If a State chooses to provide only Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers."

HHS Review, §155.110 (f)

A conflicted governing board, particularly in the exchange's formation when many important decisions are being made, has the potential to derail the exchanges success in the long-term. As such, HHS should be particularly vigilant on this issue. The regulation only states that "HHS may periodically review the accountability structure and governance principles of a State Exchange." These reviews should be required of HHS, and should have conducted on a periodic basis, and should also be triggered when there are changes to the board structure or policies.

Recommendations: HHS should be required to review the accountability structure and governance principles. The composition of a state's governing board and any potential conflicts of interest should also be a prime consideration in the state exchange approval standards (§155.105). All changes in board members should be submitted to CMS in a timely way, and all changes to the board structure should require advance approval by CMS.

§155.130 Stakeholder Consultation

It will be important for the Exchange to consult with a variety of consumers, employers, advocates and others with specialized knowledge and varied perspectives that can help facilitate enrollment and the seamless operation of the exchange. Section 1311(d)(6) of the statute lists several stakeholders that must be consulted and CMS proposes expanding that list.

We appreciate the preamble's explicit recommendation for consultation with individuals with disabilities and advocates for persons with disabilities [§155.130(a) and (c)]. Consultation with consumers (and groups that advocate on behalf of consumers) should reflect the diversity of the disability community and a variety of challenges people may face interacting with the exchange. This should include people living with physical, sensory, behavioral, mental and/or cognitive challenges or combinations of them, as well as individuals with chronic diseases or conditions who have frequent contact with the health care system and ongoing health care needs. The Exchange would benefit from consultation, in particular, with experts that can help the Exchange comply with and meet the intent of the Americans with Disabilities Act and Section 508 of the Rehabilitation Act, including by providing larger text options on websites and TTY/TDD to help consumers with certain disabilities or impairments.

Recommendation: Expand the preamble discussion of the diversity of individuals with disabilities, and their advocates, that should be consulted. Include a reference to experts in compliance with the Americans with Disabilities Act and Section 508 of the Rehabilitation Act.

In general, exchanges should consult with a panoply of health care interests, and the proposed regulation includes certain entities that must, at a minimum, be consulted. Some entities listed by CMS – health insurance issuers and agents and brokers – have serious conflicts of interest. As a result, we prefer that required consultation under the regulation be limited to issuers that offer QHPs and to agents and brokers that enroll qualified

individuals, employers or employees in an exchange, recognizing that states would retain the option to consult a broader group.

Recommendation: Limit §155.130(j) to health insurance issuers that offer QHPs and limit §155.130(k) to agents and brokers enrolling qualified individual, employers or employees in QHPs.

Two other entities should be added to the list of stakeholders consulted. First, Navigators are an important source of information and will be able to report to the Exchange common barriers to enrollment or areas of consumer confusion. Second, consultation with consumer entities with expertise in low-income tax policy would be beneficial to exchanges. Appropriate entities may be non-profit organizations or IRS-funded Voluntary Income Tax Assistance (VITA) programs. These organizations have specialized knowledge of tax issues for low-income and underserved populations and may have useful advice for communicating important information about premium tax credits.

Recommendation: Add Navigators and non-profit low-income tax programs to the list of stakeholders exchanges must consult.

§155.140 Establishment of a regional Exchange or subsidiary Exchange

The statute provides states with the ability to establish regional or subsidiary exchanges. This may be a useful option for states to consider, but it will require a significant amount of coordination and planning to ensure that the various configurations that are possible under these provisions (whether within states or across states) work in the best interest of consumers and do not result in harmful fragmentation, confusion, or increased administrative cost and complexity.

It is unclear what states may want to do in 2014 or subsequent years related to regional or subsidiary exchanges. Many of the reasons a state might want to form a regional or subsidiary Exchange could be addressed through simpler efforts that would make it unnecessary to form an entirely new exchange. Therefore, we believe that HHS should generally take a circumspect approach when considering whether to approve regional or subsidiary exchanges. States seeking to use these options must demonstrate a compelling rationale for such configurations and that the necessary elements are in place to ensure these alternative arrangements will work well.

<u>Regional Exchange, §155.140(a)</u>

Some states may see advantages in forming a regional Exchange — particularly states where consumers frequently cross state borders to commute to and from work or where one state on its own does not have a large enough population to make its Exchange attractive to insurers. But these possibilities raise a host of complex issues, which the proposed rule mentions. How well could a regional Exchange cooperate with multiple state Departments of Insurance? How would a regional Exchange provide a consistent level of

consumer protections across all member states? What happens to consumers if the state where they live withdraws from a regional exchange?

Another important issue is how a regional exchange, which would be responsible for determining eligibility for premium credits, Medicaid, and other state health programs, would coordinate 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 member state to accept their Medicaid enrollment based on the decision of the regional exchange, or individuals and families may face gaps in coverage. HHS should ensure that regional exchanges make such an agreement and otherwise abide by the requirements for a streamlined, "no wrong door" eligibility and enrollment system.

Some of the reasons to consider forming a regional or subsidiary Exchange could be addressed through the way that states establish geographic rating areas or qualified health plan service areas. These methods would likely be simpler, less costly, and more achievable for states than setting up a regional Exchange or more than one Exchange within a state. For example, perhaps two states operating separate exchanges but with a metropolitan area that straddles both their borders could ensure that some qualified health plans are available through both states' exchanges and that the plans serve the whole metro area (including by having appropriate provider networks). This would be far simpler than forming a separate exchange, either just for that metro area or between the two states overall.

The proposed rule requires a regional Exchange to submit an Exchange Plan and undergo an operational readiness assessment by HHS, just as a state Exchange is required to do. We support this proposal. We recommend that plan be tailored to the issues likely to arise for regional exchanges, such as the process for coordination among member states, extent of uniformity of consumer protections, how states will ensure that consumers do not lose protections provided by their home state, and how consumers will be appropriately informed about where to seek assistance and make complaints if necessary.

It is unclear to us why a regional Exchange would be of use for states that are non-contiguous. While this is not prohibited by the statute, such exchanges would likely raise even more complexity, but without providing the potential advantages of a regional Exchange serving contiguous states. A regional Exchange in non-contiguous states should be required to demonstrate, as part of the Exchange Plan process, the rationale the member states have for joining together and how the Exchange will overcome the additional challenges that may arise if the states do not share geographic borders or proximity.

Full-scale regional exchanges should be distinguished from multi-state efforts to partner on certain elements of Exchange development. There will be tremendous value if states are able to draw on each others' work when appropriate, as HHS has already proposed doing with the Early Innovator grants to help states modernize information technology systems.

Such collaborative efforts would be possible even without the formation of a regional exchange.

Recommendations: To the extent that two or more states seek to partner on a regional exchange, HHS should require as part of the Exchange Plan process that the states demonstrate there is a compelling reason for the formation of such an exchange. Additionally, HHS should require any regional Exchange plan to address specific challenges and issues that could arise for the participating states, including how the states will work with multiple insurance departments to ensure that health plans are properly regulated, what consumer protections will apply to consumers in a regional exchange, how states will ensure that consumers do not lose existing consumer protections, and how the states will ensure that consumers understand to whom they should address questions and complaints they may have. A regional Exchange should also be required to demonstrate how it will coordinate with multiple states' Medicaid programs to ensure a streamlined system for consumers. For example, the participating states should have to agree that their Medicaid programs will accept enrollment determinations by the regional Exchange, to avoid any gaps in coverage that could otherwise result.

Subsidiary Exchange, §155.140(b)

Subsidiary exchanges are typically discussed in the context of large states where distance and differences (for example in health care providers and insurers) might justify the creation of distinct insurance exchanges. But we think the term "subsidiary," which appears in the statute, is significant. For example, in a large state with two subsidiary exchanges, it still would be crucial to have mechanisms for coordination and policy making at the state level. While there may be value in establishing subsidiary exchanges to help serve their distinct geographic areas, the term subsidiary suggests they would be under the umbrella of a state Exchange or statewide governing board or agency. This would assist the subsidiary exchanges in coordinating with state-level insurance regulation and administration of the Medicaid program, as well as requirements for risk adjustment and risk-spreading that would be calculated at the state level. It would be problematic if subsidiary exchanges within a state were separate endeavors in terms of governance, policy decisions, or development and operations because it would lead to duplication of effort and consumer confusion.

In addition, it would undercut the consumer simplicity and administrative efficiency that insurance exchanges are supposed to provide if numerous subsidiary exchanges were established in a state. The proposed rule requires exchanges to serve distinct geographic areas no smaller than a geographic rating area. We support this requirement and 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. Although we support the requirement that subsidiary exchanges at least encompass full rating areas, we are concerned that it is not yet clear what criteria will be used to establish the geographic rating areas or how large they might be. It is helpful to have a minimum standard for the size of an area that could be considered for a subsidiary exchange, but we further recommend that states seeking to set up subsidiary exchanges demonstrate compelling reasons for doing so, in terms of how the subsidiaries will improve consumer access or understanding or improve administrative efficiency for the state or the exchange.

The rule proposes that a subsidiary Exchange could cross state borders, for example in the case of a metropolitan area that straddles state borders. We are concerned that this would create unnecessary confusion and complexity. This idea raises many of the same issues as a regional exchange, such as how coordination with multiple insurance regulators and state Medicaid programs would occur and how existing consumer protections would be preserved for a state's residents. But it holds even less potential benefit than a regional exchange. If the idea behind such cross-state subsidiary exchanges would be to help serve a transient population, it would be simpler for states to address this need by coordinating plan service areas and ensuring that one or more qualified health plans are approved to operate in both states at issue.

Recommendations: HHS should ensure that subsidiary exchanges are set up as true subsidiaries of state exchanges, in terms of governance, operations and administration. States seeking to establish subsidiary exchanges should be required to show compelling reasons for doing so. HHS should not permit subsidiary exchanges to cross state borders and should not provide more flexibility regarding the geographic areas that subsidiary exchanges may cover.

Exchange standards, §155.140 (c)

We support the provisions of 155.140(c) requiring a regional or subsidiary Exchange to meet all Exchange requirements that an Exchange operating in one full state would have to meet, as well as all of the SHOP Exchange requirements. We also support the provision requiring that a regional or subsidiary Exchange with separately governed or administered individual market and SHOP exchanges must encompass a geographic area that matches the geographic area of the regional or subsidiary Exchange. We see significant problems with permitting separately governed or administered individual and SHOP exchanges (at the state level, and in the case of regional and subsidiary exchanges). But if such separate governance is permitted, we agree that it would be best to ensure that each geographic area is treated consistently, by being part of a regional or subsidiary Exchange for both the individual and small group markets. 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

Some states had already set up insurance exchanges prior to passage of the Affordable Care Act. To the extent that such a state has covered a portion of its population no less than the percentage estimated to be covered nationally in 2016 under the ACA, it is reasonable to presume the state Exchange is in compliance with the law. Massachusetts is the only state that has met these criteria, and we think it is appropriate for Massachusetts' Exchange to be presumed compliant and for the state to work with HHS to resolve any areas of non-compliance.

To ensure that this section of the rule is clear, HHS should establish which data sources a state could use to show that it will meet the requirement to cover a portion of its overall population that is no less than the percentage that is estimated to be covered nationally in 2016 under the ACA. We recommend use of the Census Bureau's American Community Survey, which is released in September each year. It may be possible to utilize an alternative data source to determine the population of a state that is covered (for example state-generated data that is more up to date), but the methods of the alternative source should be similar to those used in the ACS.

Another important issue is when a state would have to show that it has insured a sufficient percentage of its population to be presumed compliant with the ACA. We believe the appropriate time would be no later than the fall of 2012, in order to ensure a state is on track to meet the deadlines in the ACA with its existing insurance exchange.

We support use of the Congressional Budget Office estimate of coverage nationwide in 2016 as the standard for "full implementation" of the ACA. We urge you to ensure that data is compared appropriately and consistently between the state and the CBO. For example, it is appropriate to ensure that both data sets exclude coverage of undocumented immigrants as well as the elderly population because these populations are not included in the coverage proposals of the ACA.

Recommendations: Establish the American Community Survey as the source that will be used to determine the percentage of a state's population is insured for purposes of this section. It may be possible to rely on other data sources, but this should be done only if the methods are similar to those of the ACS. A state seeking to be presumed compliant should do so no later than fall 2012. We support use of the CBO estimate of national coverage in 2016 as the benchmark for a state to meet.

§155.160 Financial Support for Continued Operations

We support the codification of states' ability to charge assessments on participating issuers, as defined by §155.160, 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 offering QHPs in the Exchange but all insurers offering plans in the state, as is the case with many premium taxes assessed by states today. While assessments only on issuers

selling coverage inside the Exchange is one allowable way to obtain funding for continued operations, if a state pursues this model it would likely 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 will seek to pass those assessments on to Exchange enrollees, resulting in potentially higher premiums inside the Exchange compared to the non-Exchange market—which could affect participation. Additionally it could run afoul of the requirement that premiums for the same product be the same inside and outside of the Exchange (likely resulting in issuers offering differing plans in the Exchange as compared to their outside market plans).

Because of these risks, we recommend that, at a minimum, the preamble - which lists a number of possible revenue strategies a state may pursue - 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 Exchange-participating carriers are assessed, including the resulting disincentive for carriers to participate in the Exchange and the higher probability of adverse selection. We also recommend that the preamble list other potential Exchange-financing mechanisms, such as assessments on third party administrators (TPAs) and reinsurance carriers, as examples. We also recommend that states be required to include in their Exchange Plans their plans to mitigate the risk for adverse selection that could result from the Exchange-financing they elect to use. We also note that states should not generally be permitted to charge different assessments on issuers to separately finance the individual and SHOP Exchanges. That could produce inequitable burdens on insurers serving only one of the markets and could produce unintended consequences that discourage issuer participation or drive up costs for one market or the other. (We separately recommend that SHOP Exchanges should similarly be prohibited from having separate governance structures from that used for the individual Exchanges.)

Related to our concerns regarding assessments imposed only on participating issuers is our concern about how consumers will be affected by Exchange assessments on carriers. 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. Because of this requirement, we recommend that the final rule clarifies that if an Exchange seeks to assess only participating 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 should be prohibited from charging an Exchange enrollment fee or otherwise passing on the cost of an assessment to 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.

We support the requirement that Exchanges must announce any assessments or user fees to participating issuers in advance of a plan year. 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 preamble to the final rule should include assessments on all carriers, as well as assessments on TPAs and reinsurers, as examples of Exchange-funding mechanisms. Further, the preamble should discuss the risks of assessing only participating issuers to fund Exchange operations. The final rule should also prohibit states from charging different assessments to separately finance the individual and SHOP Exchanges. The final rule also must clarify that carriers 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 assess carriers.

Part 155, Subpart C – General Functions of an Exchange

§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 this 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 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 the necessary data should be added to the 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 place on state exchanges as well as federally facilitated exchanges, and the data should be publicly available.

Function (d) of the exchange, establishment of an appeal of individual eligibility determinations, is a critical function of the Exchange and according to the preamble will be a subject of future rulemaking. It is important that future rules 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 must be assured of one of these forms of coverage until the dispute is settled and held harmless for any overpayments that result; provide for continuation of benefits during an appeal; provide for in-person hearings; and be completed within federally-set time standards.

The proposed rule does not address the issue of what will happen if an approved state Exchange fails to perform its functions. A process must be set up to promptly give 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 to be determined eligible for Medicaid if appropriate.

§155.200(f) Functions of an Exchange: Quality

The proposed rule codifies the statutory requirements that Exchanges must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting. The preamble indicates that HHS will issue future rulemaking on these topics. Below we offer our recommendations on a number of these issues to inform HHS as it develops rulemaking on Exchange quality initiatives.

Quality Data Collection and Reporting

First and foremost, HHS should establish a standardized set of quality metrics to ensure comparability across plans. Standard measures are critical for making quality data meaningful and useful to consumers and purchasers. All QHPs, irrespective of product type (e.g. HMO, HMO/POS, PPO), should be required to report on the same measures in the same way. At a minimum, QHPs should be required to report on accreditation status (including level of accreditation if available) and results on HEDIS and CAHPS. Quality information should be presented to consumers who are shopping for QHPs in an easy-to-understand format so they can make value-based decisions on their coverage and care.

As Exchanges evolve, they should require QHPs to report on a core set of measures on quality of care at the provider level. This set should focus on measures that matter to consumers, including outcomes measures, process measures that are closely linked to outcomes, patient experience measures, and volume and efficiency measures. Over time, these measures should be expanded to include further measures that resonate with those who receive and pay for care become available, such as functional status and appropriateness of care measures. Exchanges should also ultimately require plans and providers to be on a path to collecting patient experience information where it will matter the most – at the individual physician level. This data will be critical for driving quality for the highest cost, most complex patients as they are indicative of a level of care coordination that no other measures currently are.

Exchanges should provide consumers with comparative information on the quality of care provided by individual physicians whenever feasible. Consumers often want to select a plan that has their current physician(s) in the network. Exchanges should allow consumers the option of seeing how their physician(s) compares to others available in that plan's network. Consumers also need to know that there are individual physicians within the network who provide high quality care, reflect their values and preferences (e.g., the doctor is a good communicator, speaks their primary language, provides after hours assistance), and can be trusted to help them make the best care decisions possible. Hospital-specific data, for example, can support a consumer who is contemplating surgery and wants to know the frequency of health care acquired conditions and infections at each hospital under consideration in the health plan's network. By making quality information on

individual providers available through publicly accessible websites, Exchanges will also support patients' decisions about providers outside of the context of initial plan enrollment. Purchasers, with this quality information, will also gain insight about the level of care provided by qualified health plans.

Concurrent with the use of a nationally standardized set of core measures, exchanges should look to local innovations in quality measurement and, as appropriate, provide information useful to particular populations. Recognition of geographic and demographic differences in consumer needs and the variability of local delivery systems, as well as differences in experience with data collection across health plans and states, will strengthen Exchange quality initiatives.

In addition, an auditing mechanism is critical to ensure the reliability and validity of results so that consumers and purchasers can be confident that they are viewing accurate information and QHPs compete on performance.

Quality Improvement Strategies

The ACA included numerous provisions to spur innovation in our health care delivery system to curb costs and improve quality in Medicare and Medicaid. For example, the ACA includes policies that will link payment to quality and provider performance, creating much-needed incentives for quality improvement by hospitals, physicians, nursing homes, home health providers and others. Hospitals will have their payments reduced and have to publicly report excess readmissions that often result from poor coordination and failure to communicate effectively with patients and caregivers.

Exchanges are the critical hook to ensuring that these new models of care, along with investments in quality measure development and shared decision-making tools, are utilized by the private insurance market. HHS should provide guidance on quality improvement strategies that will encourage QHPs to align with these efforts and adopt similar programs. The strategies should also facilitate collaboration between QHPS and employers and plans in the outside market on payment pilots and other innovations. Through alignment, payers can collectively push providers to supply safe, high-quality, and efficient care.

Additionally, a critical component of successful delivery system reform and quality improvement initiatives is a strong foundation for well-coordinated primary care. HHS should direct Exchanges to prioritize quality improvement strategies for QHPs that improve the internal infrastructure of primary care practices, pay more for primary care, increase access to primary care services, and pay for value rather than volume.
Some specific strategies that Exchanges should encourage QHPs to adopt include:

- providing financial rewards to providers, including essential community providers, for integrating health IT into every day patient care in a way that aligns with or complements the meaningful use program in the American Recovery and Reinvestment Act;

- increasing payment for primary care and geriatric practitioners;
- testing innovative care models (e.g., patient-centered medical or health homes, accountable care organizations, etc.);
- supporting primary care practices, including public health clinics, in redesigning their clinic processes; and
- providing technical assistance to public health clinics and primary care practices.

HHS should set out clear metrics for all quality improvement strategies and Exchanges should hold QHPs accountable for their results – with clear goals and benchmarks – so that consumers and employers will know whether plans are hitting the quality improvement and cost containment targets over time. In particular, plans should be required to stratify data by available demographic data, including race, ethnicity, primary language, sex, disability status, sexual orientation, and gender identity, to document reductions in health disparities.

As the federal government and states gain greater experience with Exchanges, the minimum thresholds for exchanges and QHPs should not be static; instead, they should evolve to more effectively confront the quality and cost challenges facing consumers. Strategies and standards must be updated on a regular basis to keep pace with advances in measurement, consumer education, medical science, and payment.

Health Plan Rating System

The ACA directs HHS to develop a rating system to be used by Exchanges to assess plans on relative price and quality. We urge HHS to think expansively about the elements that can be incorporated into the rating system, including plan and provider level quality measures, accreditation status, affordability (reflecting both premiums and out-of-pocket costs), and quality improvement activities undertaken by the plan. In addition, the rating system should integrate elements from eValue8. eValue8 is a tool that has been used by purchasers for about a decade to assess and manage the quality of their health plans. It assesses health plans on a variety of dimensions (e.g., plan support for members with limited English proficiency, member access to a personal health record, treatment option decision support). Alignment with large private purchasers on quality initiatives will send consistent purchasing signals to health insurance issuers and providers.

Recommendation: Establish measures to help inform how well exchanges are functioning and collect data relevant to these measures that is made available to the public. Over time, as exchanges become more established, set specific benchmarks that exchanges must meet. Further clarify the appeals system, as noted above. 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.

§155.205 Required Consumer Assistance Tools and Programs

General Note: The proposed accountability measures should be built into Exchange plan requirements as well.

The overarching goal for exchanges is to facilitate consumer access to quality insurance options and intelligently harness market forces to provide the highest possible value to consumers.

Consumer assistance is integral to these goals. If consumers cannot navigate the exchange, either on-their-own (via the website or kiosks) or via Exchange provided "assistors" (call center, etc), or with the help of "outside" assistors, then the Exchange is unlikely to realize its key policy objectives.

As such, consumer assistance should be viewed as a core function of exchanges, deserving of its own standards and accountability measures.

Overarching Recommendations

1. State flexibility must be accompanied by a requirement that each Exchange assess the consumer assistance needs in its service area and adhere to measurable, auditable performance standards

Section 155.205 outlines the minimum consumer assistance tools and activities that Exchanges must provide. However, this "tools and activities" list must be augmented with a needs assessment and with measurable, auditable standards regarding the performance of the customer service activities. Requiring a needs assessment and minimum, auditable standards ensures that all consumers can use the exchange, while still allowing for state flexibility to address specific state needs and to exceed standards or meet them using a variety of methods. The use of standard performance measures will not only help consumers but also ensure that taxpayer spending on Exchange implementation and the initial year of operation is money well spent.

Recommendation: Each state should be required to outline in its Exchange Plan the steps it has taken to conduct an assessment of the consumer assistance needs within the service area; the range of consumer assistance tools and programs that it will use in light of those needs (including required tools); and a mechanism for evaluating the effectiveness of its consumer assistance efforts over time. Specific recommendations with respect to performance measures are included below.

Side note: Exchange plan comments should include similar recommendation.

2. Re-order sub-sections to clarify and reinforce consumer assistance goals

Sub-section (d) describes the requirement to have a consumer assistance function. This requirement should lead section 155.205 of the regulation, as the other topics in this

section are forms of consumer assistance. Furthermore, the regulatory language should be expanded to more fully describe the complete scope of consumer assistance functions, the "doorways" (such as call centers) for receiving consumer assistance, and the standards and performance measures that will ensure a uniformly successful consumer experience, regardless of the doorway used. Language from the preamble should be moved into this section, to remove ambiguity regarding the scope of the exchange's consumer assistance activities.

Recommendation: The content of paragraph (d) should lead section 155.205, be re-lettered as (a), and expanded to read as follows:

(1) Exchanges must include a consumer assistance function that assists consumers, directly or via referral, including, but not limited to, the following areas:

- **Eligibility and application requirements for public coverage programs, eligibility to purchase Qualified Health Plans (QHPs), premium tax-credits and cost-sharing reductions, including information about potential end-of-year tax credit reconciliation and potential consumer liability**
- **How to enroll in or renew coverage, including subsidized and unsubsidized coverage in QHPs and Basic Health Plans (BHPs) (if applicable)**
- **Facilitating applications and providing consumers with a reliable point of contact for assistance throughout the application and plan selection process**
- **Locating and understanding health plan information such as information on premiums (including applicable tax credit reductions); cost-sharing (including applicable cost-sharing reductions); benefits and coverage limits; QHP quality ratings and transparency of coverage measures**
- **How to access exchange, navigator, health plan, community-based and state government services; including how to file a complaint, health plan grievances or appeals; tax credit appeals; and providing referrals for one-one-one counseling as needed**
- **Assist consumers with issues encountered in using the Exchange website**
- **Other areas identified as being a significant need, for example, helping consumers understand how COBRA or employer coverage options should be weighed against QHP options**
- **An ombudsman function, so consumers have a way to resolve Exchange issues that cannot be resolved through other channels**

(2) Consumers must be able to access this assistance through multiple "doorways," including, but not limited to:

- **A call center (see further requirements in (a) below)**
- **A website (see further requirements in (b) below)**

- **In-person assistance**
- **A robust referral system to navigators, community-based organizations, and other external assistors**

(3) Exchanges must take steps to ensure that all exchange-provided consumer assistance is uniform, responsive, timely, and accurate. The information provided should be fully coordinated with navigators and non-Exchange consumer assistance providers, such as state-based consumer assistance centers. To these ends, Exchange consumer assistance centers, including outreach and education activities, must meet the following principles:

- **Terminology must be consistent throughout the Exchange in all consumer-facing documents. The terminology used to communicate premiums and cost-sharing, benefits, and coverage limits should be consistent with that used in the Summary of Benefits and Coverage and Uniform Terms. Further, exchanges must use internal style standards that minimize jargon and employ plain language.**

Side note: QHP standards should include similar guidelines for insurers.

- **Consumer assistance information must be easily accessible to people with disabilities and those needing assistive devices, meet the needs of those with limited English proficiency and speakers of other languages and be culturally and linguistically competent.**
- **Exchange performance of the consumer assistance function must be measured and publicly reported annually to gauge successful compliance with the requirements of this section. These measures must be auditable standards that ensure that the consumer assistance is timely, effective, easy to access, and reaches the right consumers. These measures should include, but are not limited to:**
  - **Regular customer satisfaction surveys and/or focus groups to measure overall Exchange performance with respect to consumer assistance functions, including detail by "activity" [(1) above] and "doorway" [(2) above]. Using open ended questions, surveys or focus groups must assess which consumer needs are <u>not</u> being met, if any.**
  - **Tracking accuracy of eligibility determinations made by the exchange, and use this evidence to correct related procedures that might fall into the consumer assistance function, as well as the eligibility determination function.**

Side note: please add this measure to 155.200(c) as well.

  - **Call center performance measures, as specified in (a) below**
  - **Website performance measures, as specified in (b) below**

- **Usage reports showing which "activities" [(1) above] are being accomplished using which "doorways" [(2) above] .**
  - **These public, annual performance reports must include a description of the methodology used to assess performance.**

(4) Whether provided directly or through private contractors, all consumer assistance systems and personnel, including call centers, internet systems and in-person assistance, must follow established protocols to protect and safeguard the consumers' personally identifiable information, as specified in §155.260.

3. Ready access to timely, accurate and responsive consumer assistance must trump the goal of avoiding duplication.

The NPRM preamble invites comment on the desirability of avoiding duplication of consumer assistance functions between Exchange and non-Exchange entities. The final regulation and any preamble should make clear that ready access to timely, accurate and responsive consumer assistance is the over-arching goal.

Regulators should anticipate that some duplication may in fact be necessary in order to provide a reasonable level of access for consumers. It would not be appropriate for these regulations to restrict exchange's consumer assistance functions because that could leave consumers who are seeking help and information with no place to go. For example, funding for consumer assistance programs that provide a broad range of assistance was authorized under Section 2793 but has not yet been appropriated for years subsequent to 2011. Though the programs that received grants under Section 2793 *should* assist consumers with issues ranging from appeals of health plan decisions to appeals of premium credits, depending on funding, they may not in fact have the capacity to do that work. The Exchange must still ensure that consumers have the assistance they need to resolve problems related to the exchange, eligibility determinations for premium credits and Medicaid, and Exchange plans. Further, even if multiple sources are available to provide assistance to consumers facing a problem, the great majority of consumers appropriately seek assistance from just one source until their problems are resolved. Consumer assistance programs are generally able to arrange referral arrangements among themselves to avoid duplication. The use of performance measures will help ensure that efforts to identify and reduce *unnecessary* duplication do not compromise consumer access.

Recommendation: Use performance measures to ensure that efforts to identify and reduce *unnecessary* duplication do not compromise consumer access to consumer assistance. Exchange planners should anticipate that some duplication will be needed to ensure ready access to timely, accurate and responsive consumer assistance.

4. Call Centers §155.205(a)

Exchange call centers must identify and meet the needs of all consumers. The Exchange call center should serve as a full-function customer service center providing all consumers with direct access to Exchange services. The preamble of the NPRM suggests a variety of functions for these call centers—each of these should be codified in regulation.

Recommendation: Paragraph (a) should be re-lettered as (b), and expanded to read as follows:
An Exchange must provide for the operation of a toll-free call center. The call center must:

- **Operate outside normal business hours;**
- **Provide multi-lingual and culturally competent assistance;**
- **Provide assistance to consumers and businesses on a broad range of issues, including but not limited to the assistance areas listed in (a)(1).**
- **Track and record questions and complaints from callers and make aggregate data publicly available. Use this record to identify and address prominent problems identified by callers.**
- **Track and tabulate call resolution and customer wait times and hang ups. Use this record to identify and achieve customer service goals.**

5. Internet website §155.205(b)

The Exchange website will serve as the main method of using the Exchange for many consumers. Rules in this area should specify auditable goals for usability, accuracy, and timeliness of information, as well as safeguard consumer privacy.

We support the recommended data items to be included in the website and recommend augmenting the regulation to include specific goals for usability, accuracy, and timeliness of information.

Recommendation: Paragraph (b) should be re-lettered as (c), and expanded to include these additional refinements:

- **(1)(ix) Provide health plan drug formulary information.**
- **(7) Use medical and insurance terms consistent with the Summary of Benefits and Coverage and the glossary of medical and insurance terms.**
- **(8) collect and publish reports (at least quarterly) that track traffic on the website and assess how well consumers are able to use the site to complete their tasks. More than one tracking method should be employed and included in the report, such as results from a customer feedback survey provided to the consumer as soon as he/she enrolls in coverage on the website, the number of website hits compared with the number of consumers who enroll in coverage, and/or results from consumers through a general feedback feature on the Exchange website.**

6. Healthcare.gov cannot serve as the HHS provided template for Exchange websites

The preamble to the rule invites comment on whether healthcare.gov could serve to fulfill the requirement for HHS under section 1311(c)(5) of the Affordable Care Act to provide a model template for exchanges. Despite the many impressive features of healthcare.gov, the plan comparison features of this site were built to serve a different purpose.

The Exchange website will be not only an informational site but also a transactional site. Accurate premium and out-of-pocket costs (reflecting any subsidies) are of primary interest to consumers. In order to obtain an accurate estimate, consumers will need to provide some personal information, which requires important safeguards and an interface that is comfortable for consumers. Furthermore, consumers must be able to move easily between the plan information, eligibility, and plan selection processes. Furthermore, the ideal template will integrate and prioritize the plan comparison information described in internet website (1) in a consumer friendly way. All of these requirements go beyond what is accomplished by healthcare.gov today.

Recommendation: Healthcare.gov cannot serve as the HHS-provided model template for Exchange websites

7. Exchange calculator §155.205(c)

Given the complexity of determining an individual or family's premium tax credit and cost-sharing reductions, we recommend the federal government provide a consumer-tested, model calculator for use by states.

Of particular concern is the potential for required repayment of a portion of the advance tax payments if income is higher than expected. We recommend that HHS test model language to inform consumers of this potential liability. The ideal language will fully inform consumers of the potential, without dampening their willingness to purchase coverage.

A standard method of taking less than the full tax credit should also be explored, providing vulnerable consumers with an alternate approach that might provide a tax refund at the end of the tax year.

Recommendation: Paragraph (c) should be re-lettered as (d).

Recommendation: The federal government should provide a consumer-tested, model calculator for use by states, including testing of model language to inform consumers of their potential liability should income be higher than expected. A standard method of taking less than the full tax credit should be provided.

Note that (d) consumer assistance has been moved to the top of this draft.

8. Outreach and Education §155.205(e)

Outreach and education will be critical to the success of the exchange, particularly the during the initial enrollment period taking place in late 2013. To maximize the effectiveness of outreach and education in exchanges, outreach should broadly promote coverage for individuals, families, and small businesses in need of health coverage and care; target specific hard-to-reach populations; and be coordinated among the various entities, including navigators and other state-based and community assistors.

Exchanges should design their outreach and education using the rich knowledge base obtained from other coverage outreach efforts. For example, messages often have to be repeated and reinforced by hearing the message from different entities.
An important lesson learned through Medicaid and CHIP is that outreach targeting the "uninsured"—or those in need of coverage or care—is more effective than promoting a single coverage option. When individuals hear about a specific option, they often assume it is not for them or that they are not eligible. Outreach that targets all those in need of coverage or care avoids self-selection away from certain services and is more likely to reach a wide range of individuals whose eligibility for all insurance affordability programs can be determined by the exchange.

Recommendation: Amend §155.205(e) to require the exchanges to conduct outreach and education activities to broadly promote access to coverage for the uninsured (without regard to a specific coverage option) and encourage participation.
Targeted outreach is needed to overcome barriers to enrollment that face specific hard-to-reach populations and those with health disparities.

Recommendation: Amend §155.205(e) to require the exchanges to conduct outreach and education activities to target underserved populations and those who experience health disparities due to language barriers, low literacy, race, color, national origin, geography, or disability including mental illnesses and substance abuse disorders.
States should ensure that efforts among all entities conducting outreach and education, including navigators and other community assistors, are coordinated and convey accessible, accurate, fair and impartial information.

Recommendation: Amend §155.205(e) to require that exchanges coordinate their outreach and education activities with navigators and other entities conducting such activities and ensure that all information is accessible, accurate, fair and impartial.

Outreach and education efforts should be objectively assessed to ensure that these efforts are successfully reaching the full spectrum of eligible consumers. Tabulations of Exchange assistance and health plan enrollment activities should be used to identify any populations which appear to be underserved and additional, effective outreach and educational activities identified for these groups.

Recommendation: Amend §155.205(e) to require that exchanges use Exchange performance data to identify any populations which appear to be underserved and target additional, effective outreach and educational activities to such groups.

§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.

General Requirements, §155.210 (a)

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.

Entities eligible to be a Navigator, §155.210 (b)

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 and use this information to focus Navigator funding to reach segments of the audience that have the greatest need for assistance. Analysis of the Exchange service area should look for geographic concentrations of the target audience as well as other characteristic of the likely eligible population including race/ethnicity, language, age, income, etc.

The preamble solicits comments on whether additional requirements should be placed on exchanges to make sure that funded Navigator entities 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. We also recommend that careful consideration be made before awarding Navigator funding to entities that can indirectly profit from the enrollment of individuals in specific QHPs. For example, federally qualified health center, free clinics, etc. may be well positioned in the community to be Navigators and have the expertise and staff capacity to perform Navigator duties but they could also have an indirect conflict of interest in steering groups or individuals to selecting a particular qualified health plan. Exchanges must recognize the potential for a conflict of interest and require that entities disclose potential conflicts of interest in their funding applications to become a Navigator. Applications should require entities to provide a work plan that includes staff training, staff decision support and other strategies to address any potential conflict or appearance of a conflict of interest. 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 funded entities 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 set forth in our comment to *§155.210(b)(1)(ii)* 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 audience 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).[i] In some states, the broker licensure exam requires knowledge of many types of insurance, not just health coverage.[ii] There are also licensure fees that may be nominal or may be a few hundred dollars, and sometimes fingerprinting requirements.[iii]

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. In addition, exchanges or states must avoid a requirement for Navigators to have errors and omissions insurance, which may effectively require a Navigator to be a licensed insurance broker. Navigators should be required to carry liability coverage, but not errors and omissions coverage. Individuals that work at non-profit organization serving as a Navigator would be sufficiently covered by the organization's general liability insurance.

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), direction on safeguarding consumer information, and thorough instruction on 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 entered into 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.[iv] 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.[v] 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. The final rule should also prohibit Navigators from being required to carry errors and omissions coverage. We strongly recommend that HHS develop a model training and certification program for Navigators that exchanges can adapt to include state-specific information.

<u>Prohibition on Navigator Conduct, §155.210 (c)</u>

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 this conflict is unmanageable. 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 from 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.

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.

Duties of a Navigator, §155.210 (d)

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, Basic Health (if applicable), and 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.

Section 155.210(d)(2) states that Navigators must "provide information and services in a fair, accurate, and impartial manner." The regulations must clarify that in order to meet this standard, entities awarded Navigator funding may not be employing 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 to the rules 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 state's Medicaid Certified Application Assistant programs as models for the development of a Navigator training program.

Furthermore, Navigator 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, Navigators 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 entities such as health issuers which could stand to gain financially by the actions of the staff person. 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 person performing Navigator duties. On an annual basis staff should be trained on fraud, abuse and conflict of interest and be asked to complete a conflict of interest disclosure form. Any staff with new direct conflicts of interest should either end the conflict of interest or end their employment with the Navigator entity and anyone with a new indirect conflict of interest should be monitored closely to ensure they are acting appropriately 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.

Section 155.210(d)(2) also states that Navigators are required to provide information and services in a fair, accurate and impartial manner and that such information must acknowledge other health programs. However, the final rule should be more specific as set forth in section 1311 (i) (3) of the ACA, which 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." It is estimated that 81 percent of individuals purchasing their own coverage through the Exchanges in 2019 will receive subsidies.[2] Navigators can play a major role in helping these consumers understand how to apply for these subsidies.

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 threshold 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 compentent oral interpretation of those written materials free of charge. The standard for oral language assistance requires the Navigators provide adequate and timely language services to everyone requesting assistance; this could include using a language line.

Recommendations: 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 both public and private coverage programs. 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. The final rule should specify that Navigators must meet the same standard as the Exchange regarding the

[2] "A Profile of Health Insurance Exchange Enrollees" Henry J. Kaiser Foundation, March, 2011.

provision of culturally and linguistically appropriate information, including complying with both Title VI of the Civil Rights Act and section 1557 of the Act.

Funding for Navigator grants, §155.210 (e)
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, and 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.

§155.220(a), General Rules
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 referenced 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. Failure to do so could result in incentives for brokers 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.

Recommendation: Add a new paragraph under §155.220 indicating that states electing to allow agents and brokers to enroll individuals in the Exchange should develop rules and a monitoring system to minimize adverse selection threats and prohibit steering of enrollees for reasons unrelated to the consumers best interests.

The statute requires exchanges to develop a Navigator program to provide enrollment assistance and clearly states that Navigators are not limited solely to agents and brokers. As such, the clear intent of the statute is that Exchange enrollees cannot be required to use an agent or broker. However, this idea has been discussed in at least one state. CMS should make clear that an Exchange cannot require enrollees to use the services of an agent or broker.

Recommendation: Add a new paragraph under §155.220 stating that the state (or the Exchange or SHOP) cannot require enrollees to use the services of an agent or broker in order to enroll in Exchange coverage.

§155.220(b), Web site disclosure

Section 155.220(b) indicates that the Exchange may provide information on agents and brokers on its website. If the state or Exchange elects to display this information, it should be provided alongside information on Navigators, call centers, self-enrollment or other options for enrollment that are available in the exchange. We believe that 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 if such fees are included in the premium.

Recommendation: §155.220(b) should have a new paragraph requiring that options other than enrollment through agents and brokers be displayed alongside agent and broker information and that broker fees are displayed.

If particular agents or brokers are found to be steering enrollees or violating other rules, they should be prohibited from engaging in enrollment. To the extent that individual agents and brokers are listed on the website for consumer assistance, any agents or brokers that are prohibited from enrolling in the Exchange should be listed as well.

Recommendation: To the extent that contact information for individual agents and brokers is listed, disciplinary actions against particular agents and brokers should also be listed.

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, however, should facilitate or support efficient Exchange operations, not lead to duplication, and not produce confusion for individuals and small businesses. We also strongly support the preamble's statement that exchanges would remain responsible for ensuring that the statutory and regulatory requirements pertinent to the relevant contracted functions are met. Moreover, it is clear that under section 36B of the Internal Revenue Code, as added by section 1401 of the Affordable Care Act, premium-tax credits are only available for coverage provided through the Exchange.

§155.230 – General Standards for Exchange Notices

We appreciate CMS's recognition in the preamble and proposed regulatory language that applications, forms, and notices must be provided in plain language and provide meaningful access to limited English proficient ("LEP") individuals and persons with disabilities. The implementation of the various "health insurance affordability options" envisioned by the ACA presents a range of new options and operational changes that must be explained clearly to enrollees and potential enrollees for health reform to be successful. It is thus more critical than ever that all written materials be presented in a manner that will effectively communicate to the wide range of populations affected. "Plain language" is necessary not only to clearly notify enrollees of their rights, but to properly explain the various health insurance options that may be available to consumers. Communications geared toward LEP persons and persons with disabilities is not only desirable but required by various laws, including Section 2001 of the ACA (enacting Public Health Service Act § 2719, which requires group health plans and health insurance issuers to provide notice of appeal processes in a "culturally and linguistically appropriate manner"); Title VI -- 42 U.S.C. § 2000d, *et seq.*; ACA, Section 1557, 42 U.S.C. § 18116 (Nondiscrimination).

While the proposed regulation incorporates the basic critical "accessibility and readability" concepts of plain language, access for LEP persons and access for persons with disabilities, we make the following suggestions for improvements. Proposed revised regulatory language is also provided.

Sec. 155.230(a) *General requirement.*

The proposed regulation requires that any notice provide "[c]ontact information for available customer service resources;" "[a]n explanation of appeal rights, if applicable;" and " [a] citation to or identification of the specific regulation supporting the action."

Although just referring to "notices," this section appears to apply to notices of actions to be taken by the Exchange that will affect the person to whom the notice is being sent, so we suggest that be made clear. Accordingly, the notices should also be required to include a statement of what action the Exchange intends to take . Further, rather than just a citation to the regulation supporting the action, the notice should be required to include a clear statement of the reasons for the action being taken. (*See* 42 C.F.R. § 431.210, which requires these items in notices of actions to Medicaid beneficiaries.)

Recommendation: Require all notices of action to include a statement of the reasons for the action being taken.

Since this section applies to notices of action that will trigger appeal rights, it is a bit difficult to fully comment without seeing the regulations on appeals, which are anticipated to be included in a separate proposed regulation. Nonetheless, we note here that any notice that of an action that may result in the loss of coverage is so critical that a second notice should be required if the enrollee does not respond to the first notice.

Recommendation: Require that a second notice of action be sent if the action will result in termination of coverage and the enrollee has not responded to the first notice.

Sec. 155.230(b) *Accessibility and readability requirements.*

The proposed regulation states that all "applications, forms and notices" be written in "plain language," provide "meaningful access to limited English proficient individuals," and ensure "effective communication for people with disabilities."

To assure that ALL written communications follow the required language standards, we suggest that the language be expanded to refer to "applications, forms, notices and any other documents sent by an Exchange."

Recommendation: Expand regulatory requirement for accessibility and readability to include "any other documents."

In the Preamble, CMS states that there are a number of ways by which an Exchange may provide access to LEP persons or persons with disabilities and suggests several, specifically information about the availability of oral interpretation services, information about languages in which written materials are available, and the availability of different formats for persons with disabilities. CMS seeks comment as to whether the examples should be codified. We strongly support inclusion in the final rule of, at a minimum, these suggestions to assure effective communication.

Rather than just stating that there must be access for LEP individuals, we believe that the final rule should include specific requirements for translating notices and other documents into other languages when thresholds of LEP individuals in the service area of the Exchange are met. We recommend a threshold of 500 LEP individuals or 5% of those eligible to be served by an Exchange, whichever is less. The 5% is utilized in both the DOJ/HHS LEP Guidances as well as in recently revised regulations governing marketing by Medicare Part C & D plans. The 500 comes from an existing Department of Labor regulation.

Further, all notices and other documents should be required to contain a "tag line" in a minimum of 15 languages, informing individuals how to obtain copies of the notice in their language or otherwise obtain assistance in their language.

Recommendation: Require that all notices and other documents be translated into other languages if a minimum threshold of particular language speakers live in the Exchange's service area; also, require tag lines in at least 15 languages be included at the bottom of all notices, informing non-English speakers of where to obtain assistance in their language.

The Exchange should keep track of non-English speakers and should provide notices in the appropriate language once the Exchange has information that an enrollee or applicant is only fluent in another language. At a minimum, once an LEP individual makes a request for materials in a non-English language, the Exchange should provide all subsequent notices or other documents to the individual in that language.

Recommendation: Require that notices be provided in the LEP enrollee's language once that enrollee has requested assistance in that language.

The Departments of Health and Human Services, Labor and the Treasury ("Departments") recently published guidance and proposed regulations under the Affordable Care Act to implement the disclosure for group health plans and health insurance issuers of the summary of benefits and coverage and the uniform glossary. The regulations herein should provide that the terms used in all Exchange documents should be consistent with those published by the Departments.

Recommendation: Require that terms used in notices and other documents be the same as those published for disclosure by group health plans and health insurance issuers.

Sec. 155.230(c) *Reevaluation of appropriateness and usability.*

This section requires that the Exchange must "reevaluate the appropriateness and usability of [documents] on an annual basis and in consultation with HHS in instances when changes are made."

We fully support the requirement that an ongoing obligation be placed on the Exchanges to reevaluate their documents, but the language of the proposed regulation is not clear. It would appear that the intent is for an Exchange to obtain HHS approval prior to making changes in its notices or other documents, but there does not appear to be a requirement for HHS to approve the documents in the first place. Moreover, it is not clear whether the Exchange must just consult with HHS, or whether it is actually the intent that HHS must approve any changes. As it does seem like good policy for HHS to use its expertise to review Exchange notices for readability, we suggest that it be made clear that HHS must review and approve all documents and any subsequent changes to documents.

Further, we believe that, in addition to consultation with HHS, the Exchanges should be required to consult with stakeholder representatives, specifically consumers or persons who represent the interests of consumers, in regard to notice language.

Recommendation: Require that HHS approve all Exchange documents for readability and that HHS approve Exchange's accessibility policies for LEP persons and persons with disabilities. Also, require that Exchanges provide an opportunity for stakeholders to review notices for readability and accessibility.

The following is recommended language for a revised regulation. All additions are shown in italics and bold.

RECOMMENDED REGULATORY LANGUAGE:

§ 155.230

(a) *General requirement.* Any notice required to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers, and enrollees ***announcing an action that will impact said person's eligibility for or benefits under a health plan*** must be in writing and include:

(1) The reasons for the intended action*;*

(2) A citation to or identification of the specific ***law or*** regulation supporting the action;

(3) An explanation of appeal rights, if applicable; and

(4) Contact information for available ***consumer assistance*** resources.

(b) *Accessiblity and readability requirements.* All applications, forms, notices ***and other documents (hereinafter, "documents") to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers, and enrollees, or to be published on the Exchange's website for the intention of communicating information to said persons must meet the following requirements***:

(1) ***The documents must be written in plain language.***

(2) ***The documents should use terms consistent with those set forth in the disclosure for group health plans and health insurance issuers of the summary of benefits and coverage and the uniform glossary under the Affordable Care Act published by the Departments of Health and Human Services, Labor and the Treasury.***

(3) ***The Exchange must provide for meaningful access to limited English proficient individuals.***

a. ***Tag lines must be provided on all documents in no less than 15 different languages, informing individuals how to obtain copies of the notice in their language or otherwise obtain assistance in their language.***

b. ***If there are a minimum of 500 persons or 5% of the persons in the service area of the Exchange who are limited English speaking and proficient only in another particular language, the Exchange shall be required to translate notices and other documents into those languages.***

c. Once an LEP individual makes a request for materials in a non-English language, the Exchange should provide all subsequent notices or other documents to the individual in that language.

(4) The Exchange must ensure effective communication for people with disabilities.

(5) All documents must be submitted to HHS for review of readability and must be approved by HHS prior to use. HHS must also review and approve the Exchange's plan for accessibility, both regarding LEP persons and persons with disabilities. The Exchanges must also consult with stakeholder representatives, specifically consumers or persons who represent the interests of consumers, in regard to document language.

(c) *Reevaluation of appropriateness and usability.* The Exhange must reevaluate the appropriateness and usability ***of documents*** on an annual basis. ***Any changes to documents must be approved by HHS.***

§155.240 Payment of premiums

Payment of premiums §155.240(a)

Section 155.240(a) offers states the flexibility to adopt a premium payment process that best meets the needs of the state's residents. We recognize the need to codify the statutory requirement that Exchanges permit qualified individuals to make premium payments directly to the QHP issuer if he or she elects to do so. In the preamble, HHS appropriately cites the additional mechanisms an Exchange may employ, including facilitating payments as a pass-through between the member and the QHP issuer, or collecting premiums and aggregating payments to issuers for their entire membership.

While Exchanges are obligated to permit payments to be made directly to QHP issuers, we believe that the alternative processes provide serious benefit to qualified individuals, issuers, and the Exchange. This includes having a consistent source to which payments may be made for qualified individuals, regardless of whether or not the individual's QHP changes from year to year. It also enables an individual to make a simple payment for multiple family members in the event family members are not all in the same QHP. For issuers, having the Exchange facilitate premium collection would enable the Exchange to aggregate premium payments and provide a monthly lump sum payment for all of the issuer's beneficiaries. For the Exchange, it would enable real-time data-tracking to ensure the most accurate and up-to-date eligibility information. Therefore, we believe that, similar to the provision outlined in §155.240(c) requiring SHOP Exchanges to collect premiums from qualified employers, HHS should require Exchanges to have the capacity to collect premiums from qualified individuals.

However, we believe that having multiple payment options will likely add some administrative difficulty for the Exchange, which must accurately track and maintain eligibility 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 delaying the Exchange from having complete records on all participants. This may make it difficult to ensure that grace periods are being appropriately applied and enforced, a particular concern for individuals receiving premium subsidy for which the Exchange has an obvious responsibility to maintain real-time accurate information on eligibility. HHS should require that states include in their Exchange plan how they will address any operational difficulty presented by the bifurcation of premium collection.

Payment of premiums §155.240(c)

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 function a SHOP can offer qualified employers, and is a critical component of any model in which employees are provided choice among multiple plans.

Additionally, while the ACA specifically requires that qualified individuals be permitted to pay QHP issuers directly, such a requirement does not apply to qualified employers. For the concerns cited in response to §155.240(a), we believe that HHS should require that all payments for coverage through the SHOP be paid directly by qualified employers to the SHOP for aggregation and payment to issuers.

Payment of premiums §155.240(d) and (e)

We support the provision permitted Exchanges to adopt electronic means of collecting payments by qualified individuals and employers, and the accompanying requirement that privacy and standards outlined in §155.260 and §155.270 apply.

Recommendation: HHS should require that Exchanges offer to collect premiums from qualified individuals and address any possible issues that may arise as a result of multiple premium payment options in the individual Exchange. HHS should require that all premium payments for Qualified Employers be facilitated through the SHOP for collection and aggregation.

§155.260 Privacy and security of information

Ensuring that consumers' personal information is kept private and secure is an important element of fostering the public's trust of new insurance exchanges. The proposed rule includes a number of important provisions in this area. We support applying privacy protections to the collection, use, and disclosure of personally identifiable information, as

well as the requirement for exchanges to establish privacy and security standards that are transparent, publically available and made clear to all potential beneficiaries.

Exchanges Should be Subject to Limits in Their Ability to Collect, Use, Disclose and Retain Personal Information

- In order for individuals to feel comfortable using an Exchange, they must be able to trust that any information they provide to the Exchange will be kept confidential and that it will be accessed, used and disclosed only for Exchange and other related purposes (and retained only for so long as is reasonably needed for such purposes).

- Section 1411(g)(1) of the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act" or ACA) places strong limits on the data that can be collected about a person seeking insurance coverage through an Exchange. Specifically, data collection is limited "to the information *strictly necessary* to authenticate identity, determine eligibility, and determine the amount of the credit or reduction" (emphasis added). Section 1411(g)(2) states that Exchanges can use such information only "for the purpose of, and to the extent necessary in, ensuring the efficient operation of the Exchange." Such language is an example of how to implement the collection and use limitations of the FIPPs.

- The proposed regulatory language, however, does not follow the strict limitations set by the statute. For example, proposed Section 155.26(b) would allow personally identifiable information to be collected, used, or disclosed by the Exchange if it is permitted "by other applicable law." Since such other laws may permit the Exchange to collect, use and disclose personally identifiable information for purposes not necessary for the operation of the Exchange, this provision in the proposed rule does not implement the statute and the clear intent of Congress. The final rule should appropriately reflect the strict limitations on the ability of Exchanges to collect, use, and disclose personally identifiable information.

- The limitation on collection and use of information in Section 1411(g) of the ACA also limits the collection, use and disclosure of social security numbers. These numbers can only be required from applicants seeking benefits as noted in §435.907(e)(1) and of the primary taxpayers that have SSNs as noted in §155.305 (f)(6). The use of these numbers should be restricted to activity related to determination of eligibility for health insurance affordability programs and cannot be disclosed to any third parties for purposes unrelated to eligibility determination.

- We also believe that many potential applicants for insurance through an Exchange will want to explore the Exchange website and investigate available information and coverage options before formally submitting an application for insurance. We urge HHS in the final rule to ensure that Exchanges provide individuals the option of exploring the site anonymously (including the ability to peruse the site without their

on-line activity being cached) until the individual has affirmatively indicated an interest in applying for insurance through an Exchange.

Recommendations: Adopt language in the final regulation that incorporates the strict limitations in the statute on the ability of Exchanges to collect, use and disclose personally identifiable information. Restrict the collection, use and disclosure of social security numbers for any purpose unrelated to eligibility determination. Ensure Exchanges do not collect data on individuals who are merely exploring the Exchange website for information and not applying for coverage.

Application of HIPAA Security Rule and Potential Application of HIPAA Privacy Rule

- We applaud HHS for proposing that Exchanges be required to comply with key provisions of the HIPAA Security Rule, and we urge HHS to retain this provision in the Final Rule. It is critical to building public trust that Exchanges be held accountable for implementing reasonable security measures to protect the information they are collecting from individuals.

- In the preamble to the proposed rule, HHS notes that, in some cases, an Exchange might be covered by the HIPAA Privacy Rule, either as a covered entity or a business associate. (FR 41879-41880) For those entities not covered by HIPAA, we agree with HHS that it would be unwise to apply the entirety of the HIPAA Privacy Rule. The HIPAA Privacy Rule was created to support the routine flows of patient health information among health care providers, health plans, and healthcare clearinghouses for treatment, payment and operations functions. The Rule was not specifically designed to accommodate the privacy challenges raised by Exchanges and would likely permit overbroad collection, use and disclosure of data than was intended by Congress in setting clear statutory limits on Exchanges in Section 1411(g). Consequently, even those Exchanges that are covered by the Privacy Rule should be subject to any specific rules set by HHS or states with regard to Exchanges, and the final rule should be clear on this point.

- However, the "individual rights" provisions of the Privacy Rule do provide individuals with some baseline rights with respect to personally identifiable information. For example, the HIPAA Privacy Rule gives individuals the right:

    - To receive a notice of privacy practices (45 CFR 164.520)
    - To request an amendment to personal information (45 CFR 164.526)
    - To access a copy of personal information collected about them (45 CFR 164.524)
    - To receive an accounting of disclosures of their personal information (currently being revised by the HHS Office of Civil Rights to include a right to a report of who has accessed their personal information) (45 CFR 164.528)

These provisions implement several FIPPs, and the final rule should require Exchanges to follow them or incorporate them into their policies.

- In addition, the Privacy Rule prohibits the use of an individual's personally identifiable information for marketing purposes unless that a particular marketing use has been expressly authorized by the individual. (45 CFR 164.508((a)(3), currently being revised by HHS to incorporate changes required by Section 13406(a) of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH).) Since Exchanges are required to be financially self-sustainable by January 1, 2015, selling access rights for marketing purposes might be seen as a viable potential business model. However, surveys consistently show that individuals want to be asked before their personal information is used for marketing purposes. [add cite in footnote] To ensure that individuals across the country can trust an Exchange to keep their information confidential, the final rule should require Exchanges to obtain specific authorization from individuals before they are permitted to use any personally identifiable information (including an IP address) for a marketing purpose. Requiring authorization or consent for marketing uses is also consistent with recent reports on privacy issued by the Federal Trade Commission and the Department of Commerce.[3]

Recommendations: Make clear in the final rule that even those Exchanges that are covered by the HIPAA Privacy Rule are subject to any specific privacy rules set by HHS or states governing Exchanges. Require Exchanges to follow the "individual rights" provisions of the HIPAA privacy rule or to incorporate these provisions into their policies. Require Exchanges to obtain specific authorization from individuals prior to using any personally identifiable information (including an IP address) for a marketing purpose.

Requirement to Bind Contractors

- We support HHS' proposal to require Exchanges to require their contractors to abide by the same or more stringent privacy and security standards than are applicable to the Exchange. It is critical that such standards include the limits set by Congress in Section 1411(g) of the ACA, the other express limits urged by these comments and adopted by HHS in the final rule, and additional requirements set by states. It is understandable that Exchanges will likely need to use contractors to assist them in performing certain functions, but the contract should not be permitted to become a vehicle for unauthorized and unconstrained sharing of the personally identifiable information of insurance applicants.

- Navigators, which will be funded through grant programs to be established by Exchanges, should also be subject to the requirement to abide by the same or more

[3] See, "Protecting Consumer Privacy in an Era of Rapid Change," Federal Trade Commission preliminary staff report, December 2010, and "Commercial Data Privacy and Innovation in the Internet Economy: A Dynamic Policy Framework," the Department of Commerce Internet Policy Task Force, December 2010.

stringent privacy and security standards than are applicable to the Exchange. The details of Navigator privacy and security standards should be spelled out as part of the Exchange's grant-making process or otherwise as part of state requirements for Navigators.

Recommendations: Retain the requirements applying privacy and security standards to Exchange contractors and apply these requirements to the Navigator program as well.

Penalties for Improper Use and Disclosure of Information

- We support the inclusion in the proposed rule of the statutory penalty for knowing and willful uses or disclosures of information in violation of Section 1411(g) of the ACA. We note that in HIPAA, knowing and willful violations of privacy and security regulations can be subject to criminal penalties, with civil penalties reserved for violations that are based on lack of knowledge of the law or mere negligence.[4]We believe that lesser violations – such as those based on negligence – should be subject to penalties as well, and that harsher penalties should apply when violations are knowing and willful. If HHS does not believe it has the legal authority to impose a more HIPAA-like penalty structure on Exchanges, it should seek specific authority to do so from Congress.

- In addition, the final rule should also require Exchanges to take action against contractors that it knows (or reasonably should know) are in violation of privacy and security standards. Such action can start at requiring corrective action by the contractor but should ultimately result in contract termination if compliance failures are not corrected within a reasonable period of time. (The amount of time considered reasonable should be based on the potential of the violation to put applicant personal information at risk). Exchanges that fail to take such action against contractors should be held accountable under these penalty provisions.

Recommendations: Establish a tiered penalty structure, so that civil penalties apply to relatively lesser violations of privacy and security requirements and criminal penalties apply when there is a knowing or willful violation. Require Exchanges to take action against contractors that violate privacy or security standards.

Part 155, Subpart E – Individual Market Enrollments in QHPs

[4] Sections 1176 and 1177 of the Social Security Act.

§155.405 Single streamlined application

A single, streamlined application and application process is central to the success of the No Wrong Door concept. An applicant should only be required go through the application process once in order to receive an eligibility determination for all insurance affordability programs. Applications should be accessible to a variety of audiences, including people with limited proficiency in English and people with disabilities.

Recommendation: The regulation should clarify that the single streamlined application must be accessible for people with Limited English Proficiency and people with disabilities, and it should be written in plain language at an appropriate reading level. Specifically, the written application should be 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 application does not have to be translated but instead should have a tag line providing notice in the primary language of the LEP language group of the individual's right to receive competent oral interpretation of those written materials free of charge. The standard for applications via the telephone and in-person, oral language assistance should be provided in an adequate and timely fashion to everyone requesting assistance; this could include using a language line.

Recommendation: The regulations should require that the online version of the simple streamlined application give users the option to create an account and save their work, so that applicants can start and stop the application multiple times without losing their work, and so that they can begin an application on their own, but share it with an application assistor if they need help (or vice versa; initially apply with an assistor, but later check the status of the application on their own through their online account).

The shorter and more concise the application process, the more likely individuals will be to complete it in one session, and to be able to complete it accurately such that they ultimately receive an accurate eligibility determination and enroll in coverage. Requesting extraneous information may dissuade individuals from completing the process. We also support the notion of dynamic questioning; experience with Medicaid and CHIP applications demonstrates that this form of questioning can be used to ensure that applicants are only asked questions that are specifically relevant to their own eligibility determination (for example, a male applying only on his own behalf need not be asked about pregnancy).

Recommendation: Codify a requirement in paragraphs (a) and (b) that applicants only be required to provide the minimum information necessary to complete an eligibility determination, regardless of whether an Exchange uses the model application HHS provides or seeks to use an alternative application.

To the extent that an application requests optional information, these fields should be

clearly marked as optional. The applicant must be permitted to advance through an online application without completing optional fields. When optional information (such as a non-applicant parent's SSN) would significantly streamline the application process and reduce paper documentation requirements, this should be communicated to the applicant in plain language.

We are concerned that people will be required to provide an email address in order to apply online. This has occurred in at least two states' Medicaid and CHIP online applications and puts individuals without access to email at a disadvantage and can deter them from completing an application. We recommend that the final rule clarify that individuals be permitted to apply using the online application *without* providing an email address if they so choose.

The final rule should also clarify that states may allow applicants to apply using a multi-benefit application form, provided that consumers can easily skip questions that do not apply to them.

Recommendations: Require in paragraphs (a) and (b) that any optional information requested be clearly marked as such, and require that applicants are informed that not completing such information will not affect their eligibility or ability to enroll in a qualified health plan or insurance affordability program. The final regulation should state that individuals should not be required to have email addresses to complete an online application. HHS should clarify in the final regulation that nothing prohibits states from using a multi-benefit application, as long as questions are marked and organized in such a way that consumers can easily skip questions if they are only interested in applying for health insurance affordability programs.

Given that a large proportion of applicants will likely obtain assistance completing and submitting their application, we support the provision at paragraph (c) that exchanges accept applications from multiple sources and via multiple mechanisms. In addition to accepting applications online, over the phone, and via mail/fax, exchanges should also accept in-person applications (consistent with section 1413(b)(1)(A)(ii) of the ACA). These in-person applications might be submitted to a Medicaid eligibility office or an Exchange office. Additionally, the regulation should clarify that online applications may also include applications available via mobile devices. Regardless of the method of application, however, all applicants should be able to obtain assistance with the application and enrollment process that is culturally and linguistically appropriate from an unbiased and knowledgeable source.

Recommendation: Clarify at paragraph (c)(2)(i) that an Internet portal may include a mobile device.

Recommendation: Maintain the requirement at paragraph (c)(2)(iv) that individuals be permitted to apply in person.

Recommendation: Include in paragraph (c)(2) that the tools an applicant needs to file an application should include culturally and linguistically appropriate assistance from an unbiased and knowledgeable source.

We support applicants being given notice of the exchange's information practices before the Exchange collects any personal information from them, as proposed in the preamble, but we urge that this disclosure be short and 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).

Recommendation: Codify the proposed requirement that individuals receive information about the exchange's information practices, but be clear that such information must be communicated in a concise and simple manner.

The ACA permits states to use alternative forms to the single streamlined application, but these must be approved by HHS. As the regulation suggests, the HHS should have a process in place to approve alternative forms initially and to approve any subsequent changes made to the forms.

Recommendation: HHS should issue standards for development of alternative forms and establish a process to approve such forms initially and on an ongoing basis. The Exchange must get approval for changes made to the form(s) in an ongoing basis.

The streamlined eligibility and enrollment forms are treated as one form in this regulation. These two distinct processes—the application for a determination of eligibility for a QHP or for an insurance affordability program, and enrollment in a QHP or Medicaid/CHIP—require different information from persons seeking coverage. First, for those applying for a determination of eligibility, some may want to enroll in a QHP, while other want to apply for eligibility for an insurance affordability program. Some of the information needed from those requesting an eligibility determination for premium tax credits and cost sharing subsidies is not necessary to collect from persons who are not seeking such assistance. Second, there is a difference between the application for eligibility and the form consumers will complete after they have selected a health insurance plan and are enrolling in coverage. Some personal and private information contained in the eligibility form should not be shared with the insurance provider.

Recommendations: The final regulation should ensure that HHS develops three distinct model forms:

1) **An eligibility form for those seeking enrollment in an insurance affordability program;**
2) **An abridged eligibility form for those not seeking such assistance (in which more limited information on citizenship, immigrant status, etc. needs to be collected); and**
3) **An enrollment form to transmit necessary information for the insurer.**

§155.410 Initial and Annual Open Enrollment Periods

We recognize the need to establish defined enrollment periods starting in 2014 when insurers will be required to provide health coverage to individuals seeking it. In this section, we present our recommendations for strengthening the rules on the timing of the enrollment periods, the effective dates of coverage, the content of the notices provided about open enrollment, and the use of auto-enrollment in certain limited circumstances.

Initial Open Enrollment Period, §155.401(b)

The proposed rule sets up an extended initial open enrollment period that goes into February 28, 2014. We support having a longer initial enrollment period, and believe that is necessary to ensure that individuals and small businesses are aware of the coverage options that will be available to them in the Exchange, and have adequate opportunity to assess those options. The additional time will also be helpful to states in dealing with the significant influx of people seeking coverage through the Exchanges and applying for premium credits for the first time.

Recommendation: To allow for additional time to outreach to and educate families about their coverage options, extend the initial enrollment period to end on March 31, 2014.

Effective Dates of Coverage for Initial Open Enrollment Period, §155.410(c)

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 1st of the following month for selections made by the 22nd of the month, and either the 1st of the following month or the 1st 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 in to the Exchange after January 1, 2014 and make their QHP selections towards 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.

Recommendation: Change the effective start date of coverage, so that people who make a QHP selection by December 31, 2013 would be guaranteed coverage on January 1, 2014. For QHP selections made between January 1, 2014 and March 31, 2014, coverage should be effective on the 1st of the following month.

Notice of Annual Enrollment Period, §155.410(d)

We fully support the requirement for Exchanges to send written notices to each enrollee about annual open enrollment. The notices will be an important reminder for individuals and families to reassess their coverage needs, have their eligibility for premium credits and cost-sharing subsidies re-determined, and make any necessary changes to their coverage for the next calendar year.

In the preamble, HHS indicates that it is considering codifying the requirement that such notice be sent no later than 30 days before the start of the annual enrollment period. We believe that a 30 day period for the notice is appropriate, and we support the inclusion of this requirement in the final rules. In addition, we recommend requiring Exchanges to send a reminder notice to individuals who have not made a QHP selection 30 days before the close of the open enrollment period.

We recommend including in the final rule a requirement for the notices to include, at a minimum, the following information:

- The date that open enrollment begins and ends
- Language that makes clear that open enrollment is the only opportunity to enroll in new coverage or change coverage, unless there is an event that triggers a special enrollment period
- The penalty for being uninsured
- The availability of premium credits and cost-sharing subsidies
- Language indicating that open enrollment is the time for re-determining eligibility for premium credits and cost-sharing subsidies
- Where to obtain available information about QHPs and premium credits and cost-sharing subsidies, including the website, toll free call center, and through Navigator assistance

Recommendations: Maintain requirement to send a 30-day notice before the start of each annual enrollment period. Include a requirement to send a reminder notice 30 days before the close of the open enrollment period. The notices should include important information about options for coverage and the implications of being uninsured.

Annual Enrollment Period, §155.410(e)

In subsequent years, HHS proposes to set the annual open enrollment period from October 15 through December 7. We recommend lengthening the enrollment period somewhat by setting it to occur between October 15 and December 15. During the annual enrollment periods, Exchanges will not only be processing QHP selections, they will also need to conduct eligibility redeterminations for people receiving advance payments of premium credits as well as process new applications for premium credits and Medicaid. Thus, Exchanges will experience a significant increase in workload during the open enrollment period. Lengthening the annual enrollment period will give state Exchanges more time to process applications and QHP selections, which will help to alleviate some workforce issues associated with these functions.

Extending the annual open enrollment period to December 15 should still give Exchanges and QHPs sufficient time to process enrollment for coverage starting on January 1 of the next year. Moreover, since December 7 is a fairly random date, there is a risk that people will forget to submit their applications and QHP selections by that time. Alternatively, December 15 is a deadline that people are more likely to remember.

Recommendation: Change the timeframe of the annual open enrollment period to October 15 through December 15.

Effective Date for Coverage After the Annual Enrollment Period, §155.410(f)

We agree with the proposed rule to require Exchanges to ensure that coverage is effective as of the first day of the following benefit year for individuals who make a QHP selection during the annual enrollment period.

In the preamble, HHS indicates that it is contemplating auto-enrollment of individuals in certain cases when an enrollee fails to make a QHP selection, and seeks comment on this issue. While many states currently have a method for auto-enrolling individuals who do not make a managed care selection in Medicaid, the practice of auto-enrolling in the Exchange raises some concerns. For example, Medicaid beneficiaries typically do not have to make premium payments to Medicaid managed care plans. Individuals eligible for premium credits in the Exchange, however, must pay their share of the premium costs for the plan they choose. If individuals are auto-enrolled into a plan, they may not know that they have to send premium payments or to which QHP to send the premium payments, which would result in eventual disenrollment.

Despite these concerns, we believe that *very limited* use of auto-enrollment in the Exchange might be necessary. But first and foremost, before any auto-enrollment occurs, Exchanges should be required to make every effort to provide clear and sufficient notice to individuals about the need to make a QHP selection. Such notices should include information that failure to enroll in a QHP could result in the loss of eligibility for premium credits and cost-sharing subsidies.

In cases where individuals receiving a premium credit are enrolled in a QHP that is decertified or no longer offered, we support auto-enrollment of such individuals into another QHP if, after sufficient notice, the individuals still fail to make a QHP selection. To the extent feasible, these individuals should be auto-enrolled into another QHP that maintains the same or similar provider networks, and has a similar premium and cost-sharing structure. The second lowest cost silver plan should not be the default plan.

In addition, we believe it would be appropriate to do auto-enrollment in instances where there are mergers between issuers or when one QHP offered through a specific issuer is no longer offered but there are other options available to the individual through the same issuer. To reiterate, auto-enrollment should occur only after sufficient notice is provided to enrollees and individuals still fail to make a QHP selection. In these circumstances, individuals should be auto-enrolled into a QHP being offered by the merged issuers, or a QHP available through the same issuer that discontinued the QHP product in which the individual was initially enrolled. However, these issuers should be the default plan only if they offered a QHP that has similar provider networks, premiums, and cost-sharing structures to the one in which the individual was initially enrolled.

In these limited applications of auto-enrollment, we recommend strengthening the rules to protect consumers by requiring that Exchanges provide individuals a period of 90 days from the time they are auto-enrolled to change plans without cause. Medicaid managed care has a similar requirement to provide beneficiaries with a "free look" period to ensure that beneficiaries have a chance to assess whether the plan in which they were auto-enrolled meets their needs. We believe that such a requirement is also critical for individuals in the Exchange who are auto-enrolled into a QHP.

Recommendations: Allow auto-enrollment in very limited circumstances, and provide individuals who are auto-enrolled with a "free look" period that would allow them to change plans without cause.

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[i] 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).

[ii] 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.

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

[iv] 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.

[v] 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.

§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 tiers of coverage, at least in some situations.

Effective Dates, § 155.420 (b)

Generally, special enrollees will be entitled to enrollment 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 enrollments 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 still leave some other people with gaps in coverage. For example, if someone suddenly loses a job that provided coverage and has no COBRA right, they could be without coverage from the 23 of one month until the first day of the second following month. We saw many cases of sudden layoffs during the recession. People newly eligibly for premium tax credits may also have to wait over a month for enrollment to be effective.

Further, 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. 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. 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. Exchanges should be required to allow new and special enrollees to print out temporary identification that would verify to providers that the plan would retroactively pay the claim once plan enrollment is processed.

Recommendation: To prevent enrollment gaps, we recommend that special enrollees be given 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 qualified health plans 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 the new enrollment.

Length of special enrollment, § 155.420 (c)
This section provides 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 enrollment gaps. Recommendation: Specify that exchanges and qualified plans must allow special enrollees to apply for coverage in advance of a known event that will trigger a special enrollment period.

Special enrollment periods, § 155.420 (d)
This section sets forth the various triggering events that will 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 Indians, consistent with the statute. It also appropriately lists other reasons that may arise midyear and should allow a person to enroll in a QHP, including when a person gains citizenship or a lawfully present status, when errors or misrepresentations about exchange eligibility caused the nonenrollment or enrollment in the wrong plan, when a person moves into a new plan's service area, when a QHP violates a material provision of its contract, when a person newly becomes 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 national disasters as one exceptional circumstance, and we agree that emergency temporary relocations due to storms have necessitated plan changes in the past. We support the broad language in (d)(9) ("other exceptional circumstances"), which could allow for special enrollment if there were major changes in an insurance market or if an exchange needed an additional period to encourage enrollments.

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, Peace Corps health plans, eligible employer-sponsored plans, individual market plans, grandfathered plans, or other coverage such as a high risk pool – as long as the coverage does not consist only of essential benefits. 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.

Please clarify that a person losing any of those sources of coverage qualifies for special enrollment – that is, if you have two of the sources of coverage on the list, and lose one of them, you 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, they should also qualify for special enrollment whether or not they qualify for premium credits. (In this instance, we would consider COBRA to be an employer-sponsored plan too.) For example, COBRA can be prohibitively expensive, and we anticipate that people who cannot afford COBRA would need special enrollment rights in 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 dependent through "marriage, birth, adoption or placement for adoption." Only some states currently permit gay marriage, but other states allow for other arrangements, such as civil unions or registered domestic partners, for gay persons who are not permitted to marry. This section should be expanded to cover such arrangements also. 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. For example, a QHP may commit such an erroneous action by enrolling an individual into a different plan than the one the individual enroll through the Exchange. 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 an "or."

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 clariftying that the special enrollment right is triggered by the exchange making a determination,, and not the date that the 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 sufficiently to alter their credits. 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 that population will help to get them into the program. Tax penalties for failure to maintain coverage should dissuade people from intentionally delaying enrollment, making any further restrictions on enrollment unnecessary for the credit-eligible population.
We recommend an additional qualifying event:

People with disabilities who are on COBRA 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.

Recommendations: Clarify that a person losing any source of minimum essential coverage is entitled to special enrollment, even if they had multiple coverage sources previously; 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); clarify that the definition of dependent includes dependents under state law or the plan rules, and that civil unions, in states that permit them, are treated as special events as well as marriage; 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 that way; add special enrollment periods for people reaching the COBRA disability extension period, for pregnant women, and for people leaving incarceration; add examples to the regulations.

Loss of coverage, § 155.420 (e)

(e)(1) explicitly excludes people who lose COBRA due to failure to pay premiums on a timely basis from special enrollment. However, we think these are people who need special enrollment rights. 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.

Recommendation: Delete (e)(1).

Limits on special enrollment periods, § 154.420 (f)

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. However, we believe that people 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 they may therefore need to adjust their coverage tier to fit their budget; a pregnant woman or a household that has added a dependent with a special health care need may need more coverage than previously; a person who received misinformation about QHPs may also have received misinformation about the coverage tiers.

Recommendation: Delete the prohibition on changing tiers of coverage during a special enrollment period.

Information about special enrollment rights

The rules do not provide for any notices about special enrollment rights. We are therefore not sure how people would find out that they are entitled to special enrollment prior to the expiration of the 60-day period.

Recommendations: Add a new subsection on notice. 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. They 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 exchanges. 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 eligibility period.

Fix problem with special enrollment periods for employer-based plans:
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 their employer's plan at that time, yet is no longer qualified for premium credits on the exchange. (See example 6 in 1-36B-2.)

§155.430 Termination of Coverage

Termination Events, §155.430(b)

We agree with the proposed rule requiring exchanges to permit an enrollee to terminate his or her coverage in a QHP given appropriate notice is provided. However, the rules should specifically define what constitutes appropriate notice. Without specifying a timeframe and a standard for QHPs to follow, QHPs could be slow to process termination of coverage requests. In some circumstances, such delays could lead to individuals and families paying additional premiums for coverage they do not want or need. We recommend that in cases of voluntarily termination of coverage, a 14-day notice should be sufficient to allow QHPs and exchanges to process the necessary paperwork.

Recommendation: Specifically define that 14 days constitutes appropriate notice for voluntarily terminating coverage in the exchange.

Termination of Coverage Tracking and Approval, §155.430(c)

We support the rules requiring exchanges to establish procedures that QHPs must follow for maintaining records of coverage terminations, and to track such events. We also believe that the requirement for exchanges to provide reasonable accommodations to individuals with mental or cognitive conditions is critically important and should be retained in the final regulation.

Recommendation: Maintain provisions in the final rule.

Effective Dates for Termination of Coverage, §155.430(d)

We agree with the proposed rules specifying the effective dates for termination of coverage. In particular, we strongly support the provisions that would essentially require exchanges and QHPs to provide at least 30 days notice prior to terminating coverage. Sufficient notice is important to helping individuals prepare for the loss or termination of coverage, and make necessary plans.

Recommendation: Maintain provisions in the final rule.

Part 155, Subpart H – 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. This represents a change from current practice in the small group market in which employers often offer only one plan to their workers. By facilitating transactions between a small business and multiple insurance carriers, SHOP Exchanges have the potential to ease administrative burdens and provide enhanced customer service functions for employers while also giving small business workers a broader array of plan options.

However, while increased choice of plans 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 HHS should include in the preamble caution for states or Exchanges that wish to pursue increased 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 do so, but should evaluate and prepare for the potential impacts on risk selection and age discrimination that may result from a new model for small group coverage in which employees of the same business are dispersed across multiple different 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 mimicking, the work being done to develop the

Exchanges that will serve the individual market. In other areas, though, SHOPs must be developed in a way that takes into account the reality that the shopping for and purchase of health coverage for the employees of small employers involves very different considerations than it does for large employers. In our comments below we offer suggestions that will go a long way toward making it desirable for small employers to purchase health coverage through the SHOP, for the employer and employee interaction with the SHOP to be a positive experience, and for the groundwork to be laid which will allow states in the future to either expand their SHOP to serve larger employers, or to merge their small business and individual markets.

§155.705 – Functions of a SHOP

§155.705(a) – Exchange functions that apply to a 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 rules that *should* be required of the SHOP in the final rules 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 make it a requirement of Exchange 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 their 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 such a calculator even though they will not qualify for the individual premium tax credits. A calculator would allow employees to see their employer's premium contribution (as the preamble points out, this is fairly standard in the current market). An employee will make their own decision about which offered plan to select, but a calculator will allow them to keep a running tabulation of the different levels of their own potential premium contributions, all the while taking into account their employer's contribution. This will also allow employees to become more educated and savvy consumers about the costs of different plan options. Lastly, as some individuals will move between coverage in the Exchange and though the SHOP, there are benefits of familiarity if a premium calculator exists in both entities.

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

The regulations appropriately codify 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 within the SHOP overall. As the preamble recognizes, if an employer offers plans across multiple actuarial value tiers, it is likely that older or sicker employees may select more costly comprehensive plans (e.g. gold or platinum plans) while younger or healthier employees would 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 higher costs over time. If risk adjustment and other risk mitigation tools prove to be inadequate, the gold and platinum tiers would exhibit upward spiraling costs over time, eventually making such plans unaffordable for employees and/or making such plans no longer viable and thus no longer available through the SHOP. Higher premiums for more comprehensive plans would also adversely and disproportionately impact older or sicker employees, especially if the small employer is only providing a flat dollar amount (i.e. defined contribution) to all employees and such employees would have to bear a larger share of the cost of coverage over time.

Even if an employer offers plans only within one tier of coverage, there is still a potential for adverse selection. Certain plans within the same 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 note that this problem should be mitigated not just through risk adjustment, but through enforcement of robust marketing standards and other protections against cherry picking.

Also of concern is the effects of age rating in the case of the SHOP, regardless of whether an employer picks one plan, one plan level, or another menu of options for his or her employees. Since QHPs generally 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. In contrast, in the current small group market, each group is generally charged a uniform composite rate for all employees based on the underwriting of the entire group, resulting in no difference in premiums for the same plan between older and younger members of the group.

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 premium might be $250 would only have to pay $100. On the other hand, a 60-year-old employee, whose premium may be up to three times that of his younger colleague, could be saddled with $600 of a $750 monthly premium.

The proposed rules should therefore require each SHOP to establish a process for charging a composite rate to small employers that would effectively mirror the composite rate setting approach used in the current small group market. The requirement for premium aggregation by the SHOP will facilitate this process. In such a process, 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 would then cover a fixed percentage (or fixed amount) of the total cost and distribute the remainder of the costs equally to all employees regardless of age. This could be an explicit requirement for employers to participate in the SHOP (but as noted below, would not be particularly burdensome). 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. This approach would not burden employers because employers make contributions to their employee's health coverage in a similar way today.

Establishing a process to calculate a composite rate for a small employer if employees are given a choice of multiple QHPs (i.e. all plans within a SHOP, or all plans within a tier and such tier includes numerous choices) is more challenging. In this case, SHOP Exchanges could be required to adopt a model similar to that employed by the Connecticut CBIA Exchange, in which an employer can set a contribution amount as a percentage of the employer group's composite rate for any given individual or family premium category of a "reference" plan elected by the employer. All employees then pay a uniform flat rate for a given family category in that reference plan under the procedure outlined above. Employees that want to purchase an alternative plan are responsible for paying the dollar amount of their uniform employee share under the reference plan, plus or minus the difference in the non-age-adjusted base premium between the reference plan and alternative plan. (Employers, however, would be responsible for paying for the portion of the premium difference that is due to age-rating). Using such an approach, older employees effectively receive a larger dollar contribution than their younger colleagues when purchasing an alternative plan because their age-adjusted premiums are higher. This method would help mitigate the impacts of age rating for older employees, as well as ensure sufficient predictability for the employer in terms of anticipated health costs. For a complete description of this model, see "Rick Curtis and Ed Neuschler, *Small-Employer ("SHOP") Exchange Issues* (Washington: Institute for Health Policy Solutions, June 2011).

Alternatively, in the case of an employer offering a wide-ranging choice of plans, the SHOP could be required to 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 moderate such differences. 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 minimum participation rate is established, the requirement should be considered to be met by the participation the required percentage, whatever it is, of workers without other sources of creditable coverage 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 creditable coverage such as spousal coverage, Medicare, or Medicaid.

<u>§155.705(b)(4) – Unique functions of a SHOP</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 more easily then be able to collect premium shares from workers and understand their business costs for providing worker coverage.

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.

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

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 that plan rates 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 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.

§155.705 (b)(7) – Unique functions of a SHOP

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.

§155.710 – Eligibility standards for SHOP

We support the interpretation that a small employer includes employer groups of up to 100 employees (or up to 50 employees in states that elect to wait until 2016 to adjust the upper limit of the small group definition to 100), but does not include sole proprietors or

otherwise self-employed individuals who constitute a group of 1 (or any family members that would be included in a family policy). We believe that it would be inappropriate to require sole proprietors or otherwise self-employed individuals to pursue coverage via a SHOP because it would bar some otherwise eligible individuals from receiving income-based premium tax credit or cost-sharing subsidies in the individual Exchange. Furthermore, it would pose an administrative burden for the individual Exchange 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 presented the best value coverage to the individual. Such a policy, 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. As a result, the only viable option is to limit sole proprietors or any other employer group of one to access coverage through the individual market Exchange rather than a SHOP.

Recommendation: The final rule should clarify that sole proprietors or otherwise self-employed individuals are eligible for coverage through the individual Exchange, not the SHOP.

§155.710(b)(3)(ii) and (c) – Eligibility standards for SHOP

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 either within a state or across two or more states may have employees whose service areas may be vastly different. This provision prevents employees not located at the primary work site from being limited to coverage options that may not serve the appropriate service delivery area.

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 ensure that all required functions are provided 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 how coordination and information sharing would occur between Exchanges if small employers provide coverage through multiple Exchanges 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 obtain coverage through multiple Exchanges.

§155.710(d) – Eligibility standards for SHOP

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 small group for the purposes of the SHOP, until such time when the employer either leaves the SHOP or becomes ineligible for other reasons.

§155.715(a) – Eligibility determination process for SHOP

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.

§155.715(b) – Eligibility determination process for SHOP

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.

§155.715(c) – Eligibility determination process for SHOP

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.

§155.715(d) – Eligibility determination process for SHOP

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.

§155.715(g) – Eligibility determination process for 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 includes information regarding other coverage options for which the employee and his or her family may be eligible, including, but not limited to, Medicaid, CHIP, Basic Health Plan (if a state has elected to provide a BHP) 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. The final rule must also clarify that workers losing SHOP coverage have a COBRA continuation right.

§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 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. The preamble considers giving employers 30-days advance notice that this election period is approaching. We would 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 a 60-day advance notice of the employer election period. Regardless of the time period for advance notice, we strongly support the requirement of a standardized timeframe by which advanced notice of the election period must be provided to all employers in the SHOP Exchange. 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…" to clarify that this period must be uniform for all carriers. The final rule must also clarify that the employee open enrollment period may be no less than 30 days in advance of the end of the plan year.

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.

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 state that employers must receive 60 days advanced notice of a uniform employer election period. It should also require SHOPs

to provide a uniform employee open enrollment period of no less than 30 days. The rule should state that employees must receive advance notice 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 requires 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.

Part 155, Subpart K – Exchange Functions: Certification of Qualified Health Plans

§155.1000 Certification Standards for QHPs

General certification criteria, §155.1000(c)

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. 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 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 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 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 a state to have an Exchange that is compliant with the ACA, the Exchange must have the discretionary ability to certify a QHP based on a determination that the QHP is in the interests of qualified individuals and qualified employers in the State. Unfortunately, there are currently bills pending in state legislatures that would require the Exchange to take any qualified plan. Some also prohibit "active purchasing." Such provisions, if enacted, would be in conflict with § 1311(e)(1)(B) of the ACA because they effectively take away an Exchange's ability to make a determination of whether a particular QHP's participation is in the interests of enrollees.

HHS should clarify that state statutory or regulatory provisions that take away the ability of Exchange leadership to make a determination that a QHP is or is not in the interests of participants 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 a health plan as a QHP. Exchanges should consider historical rate increases and conduct in determining whether offering a health plan is in the interests of qualified individuals and employers. The final rule should clarify that state statutory or regulatory provisions that take away the ability of Exchange leadership to make a determination that a QHP is or is not in the interests of participants violates the ACA.

Defining "premium price controls," §155.1000(c)(2)
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 nowhere else defined 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."[v] 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 plans' premiums and any premium increases into account in determining a plan's eligibility to participate.[v] 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. The preamble also notes that an Exchange may wish to set additional selection criteria for QHPs, including examples such as the "reasonableness of the estimated costs supporting the calculation of the health plan's premium and cost-sharing levels."

We encourage you to provide, in regulation, 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: Define "premium price controls" narrowly to include only requirements that would require QHPs to set a particular price for a particular product. 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 to negotiate premium prices with QHPs.

§155.1010 Certification process for QHPs

Multi-State Plans, §155.1010(b)

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 an additional 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 individuals and employers in each state. 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, additional certification requirements, benefit standardization, and other active purchasing strategies. If MSPs are not required to meet any and all of the Exchanges' programmatic and operating requirements, it could undermine their efforts to serve consumers and 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 the responsibility for certifying MSPs. We urge you to work with officials at

OPM to ensure that MSPs meet not only the minimum federal requirements for the program, but also any additional requirements that an Exchange may establish. Recommendation: 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.

Completion Date, §155.1010(c)

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.

Ongoing compliance, §155.1010(d)

We support the requirement that an Exchange must monitor QHP issuers for demonstrating ongoing compliance with the certification requirements. However, we are concerned that neither the rule nor the preamble explains 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 plans may not be complying with the minimum certification requirements. This investigation should take place within a limited amount of time, such as 30 days. Further, more consistent formal monitoring should be required 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," does not 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. If plans fail to do so, exchanges must be required to remove the plans' QHP certification and cease to include the plans in the exchange. The process for plan decertification (Section 155.1080), including the provision of a special enrollment period for the decertified plan's enrollees, must take place at this time.

We are also concerned that the rule fails to clarify how HHS will ensure that exchanges are monitoring QHP issuers for demonstration of 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 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, 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, §156.210 QHP rate and benefit info

The cost of insurance is still the top concern of many families. This will be especially true in the Exchange where families may face significant premiums and cost-sharing and taxpayers will bear the balance of premium hikes through premium tax credits.

§155.1020(a), Receipt and posting of rate increase justification

This provision states that the Exchange should receive "a justification" for a 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 does not apply (rate review for plans that meet the federal standard of "subject to review). 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 those 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 helpful for the Exchange to have complete documentation regarding the rate increase, especially to the extent that much of this information will already be publicly available. For all QHPs with rate increases, the Exchange should post a link to their rate justifications so that they are transparent to consumers shopping for coverage.

Recommendation: Amend §155.1020(a) to indicate that the Exchange should receive all documentation related to a rate that was subject to review by regulators, whether or not it was found to be unreasonable. Require complete justification of all QHP rate increases and state that links to any rate increase justifications for a QHP must be available on the Exchange website where the QHP's premium and cost-sharing information are quoted.

When a rate has been found to be unreasonable, that fact should be prominently displayed on the internet website of the Exchange, in every place where premium and cost-sharing information are quoted. The rate justification process will yield valuable information that consumers should have in an easily accessible manner. It would be contrary to the intent of the statute, which puts a primacy on transparency, to fail to indicate this, to force consumers to go through a separate website to find this information, or to hide the rate review result in vague language.

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. This information should be displayed everywhere the plan's price is quoted with a bolded statement in the same font size used to display the premium: "This premium rate has been determined to be unreasonable." Consumers should be able to click on a link to a plain language description of the final determination and how it was conducted.

Recommendation: In addition, to ensure the consumer is fully informed that an extensive professional review process has found a rate increase to be unjustified, a "pop-up" warning box should appear when a consumer is 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 this premium rate has been determined to be unreasonable.

§155.1020(b), Rate increase consideration

As in the statute, the regulation says that the Exchange should consider rate increases in deciding 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 for comment on whether to certify plans with proposed rate increases, based on their submitted justifications.

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 states 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 for QHP certification based on the size of their rate increases compared to those of other plans with comparable enrollee populations and benefit packages and/or 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 and Exchanges should be required to submit a detailed explanation of how they will comply with the requirements to consider rate increases in QHP certification in the plans they submit to HHS for Exchange 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 existing rate review process is leveraged for purposes of the Exchange, the Exchange must still have an independent process to consider any rate justification information 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 conduct an independent assessment of a plan's rate justification and/or unjustified rate increase pattern before certifying the plan as a QHP. The consideration of a 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 based on rate increases. The final rule should outline the process that states must use to consider rate increases in QHP certification and Exchanges should be required to describe their process for considering rate increases in their Exchange approval plans to HHS. The final rule should describe how HHS will enforce the requirement that Exchanges consider rate increases in the QHP certification process.

The rate review process is important to overall cost containment. Improvements made under the Affordable Care Act ensure that states have the resources to conduct a more thorough, professional, and public review of rates. States' laws on rate review vary. Some states have the authority to reject or modify rate increases or actively negotiate with plans to achieve a better value for consumers. Insurance departments will continue this work on plans offered inside and outside the Exchange.

Recommendation: Reaffirm in the regulation that state insurance commissioners continue to have the ability to carry out their state authority on rate review, including denying or modifying proposed rate increases of QHPs.

§155.1020(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 the plans' 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 other standards including the requirement that QHPs do not employ benefit designs that have the effect of discouraging the enrollment in such plans 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" should be expanded to include specific information about amount, duration and scope of benefits. It would also be appropriate in

the benefit and rate requirements to clearly indicate whether certain state required benefits are covered. 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 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: Add more specificity to the required benefit and rate information to ensure that the Exchange has specific information about the amount, duration and scope of benefits covered, and changes to such benefits. Specify by when each year rate, benefit, and cost-sharing information must be provided.

§156.210(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 in the individual Exchange applies not only to rates for enrollees who enter a QHP during open enrollment, but also to those who enter during special enrollment. Given that a "benefit year" is defined in section 155.20 as a calendar year, individuals who enter a QHP during a special enrollment period must receive the same rate as individuals who enrolled in the QHP during the open enrollment period for that benefit year.

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

§156.210(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. The submission deadline should be prior to the deadline for QHP certification and/or recertification.

Recommendation: 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. Specify the submission deadline for QHP rate and benefit information.

§156.210(c) Rate justification

Like we recommend for submitting general rate information, QHPs should be required to submit justifications for rate increases not just prior to their implementation, but prior to the QHP certification and/or recertification deadline. We support Exchanges leveraging existing rate review processes for efficiency, 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 process, the QHP must submit further information to the Exchange.

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

Recommendation: QHPs should be required to submit rate increase justifications prior to QHP certification and/or recertification deadlines. 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.

§155.1040, §156.220 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 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, by Exchanges to determine if a health plan is in the interest of the qualified individuals, and by State Insurance Commissioners and HHS in their oversight and enforcements activities. 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.

§155.1040

General Requirements, §155.1040(a)
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 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 Internet Web site. 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).

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.

Use of Plain Language, §155.1040(b)

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 it if 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.

Transparency of cost-sharing information, §155.1040(c)
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 of 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.

§156.220

[Note – except for §156.220(a), the comments below largely reiterate the discussion above, except from the QHP issuer perspective rather than the Exchange perspective]

Required Information, §156.220(a)
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.

Reporting Requirement, §156.220(b)

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 to 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 Internet Web site. 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 enforcement process. In addition, HHS should consider utilizing Exchanges as an aggregator/ disseminator of transparency in coverage information to minimize burden and increase efficiency of the reporting process.

Use of Plain Language, §156.220(c)

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 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.

Enrollee cost-sharing transparency, §156.220(d)
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 also should 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. The consumer 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 have access to or use 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. The consumer should also be able to choose how they would prefer to receive the information, with a paper option always available.

§155.1045 Accreditation Timeline

The proposed rule proposes that Exchanges must establish a uniform period following certification of the QHP within which a QHP issuer that is not already accredited must become accredited. Accreditation is a critical tool for ensuring that health plans are providing high quality care and good customer service. Nationally recognized accreditation can act as a seal of approval that gives consumers and employers confidence in the product they are purchasing. It can also be used by health issuers themselves to identify areas for improvement.

We support the statutory requirement that QHP issuers must be accredited. We do, however, appreciate the concern that some leeway may be necessary to allow new issuers that are seeking accreditation to be certified by and sold in Exchanges.

To reconcile these competing needs, first, we strongly urge HHS to establish a federal accreditation timeline rather than rely on states to individually establish processes. While state flexibility is warranted in a number of areas related to Exchange implementation, a federal accreditation timeline would minimize burden on all parties. States could focus on other areas of implementation and QHP issuers operating in multiple states would not be subject to competing timelines.

Second, we recommend that HHS adopt a maximum grace period of one year after certification of a QHP during which a QHP issuer must become accredited if it is not already accredited. We believe 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, they should be required to document extenuating circumstances causing the delay and Exchanges should have the authority to make limited extensions to the grace period. HHS should also consider limiting the accreditation grace period to new issuers. Health insurance issuers operating prior to January 1, 2013 that wish to participate in Exchanges should be encouraged to seek accreditation prior to January 1, 2014.

Recommendation: HHS should require Exchanges to adopt a one year timeline after certification of a QHP during which a QHP issuer must become accredited if it is not already.

§155.1050 Establishment of Exchange Network Adequacy Standards

The rule proposes that Exchanges make health insurance and therefore health care available to a variety of consumers, including those who reside or work in rural or urban areas where it may be challenging to access health care providers, by requiring Exchanges to "ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees." We strongly support this goal. The Affordable Care Act sets a number of standards to ensure that comprehensive plans are offered in the individual and small group markets, including the requirement that plans provide the essential benefits package and meet actuarial value requirements. An inadequate provider network, however, would undermine these requirements (for example, actuarial value does not take into account provider networks).

While we agree that network adequacy standards need to be appropriate to States' particular geography, demographics, local patterns of care, and market conditions, national network adequacy requirements should serve as a floor to ensure that the enrollees of QHPs have a sufficient choice of primary care, specialty care and tertiary care providers to have meaningful, timely, and affordable access to the services they need.

Network adequacy requirements

The ACA requires the HHS Secretary to establish network adequacy requirements for health insurance issuers seeking certification of QHPs. However, the rule proposes to delegate this responsibility to each Exchange. We believe that the final rule should establish national standards that will serve as a minimum level of protection for network adequacy across the country. Such standards can be broad enough to ensure that they are appropriate to each state's needs.

In particular, we believe that the NAIC's Managed Care Plan Network Adequacy Model Act provides and appropriate and balanced framework for national network adequacy requirements. 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 requirements 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 in defining the national minimum standards and leveraging state and private oversight and enforcement mechanisms. It also simplifies the certification process, avoids duplication of effort and reduces the administrative burden on the Exchange, QHPs and States.

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 -- which will include 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". As a result, these plans may not currently be subject to the same requirements regarding network adequacy. Health indemnity plans that seek to be QHPs should also be required to meet the same or similar 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 have a sufficient choice of providers accepting their health plan to meet the minimum national network adequacy standards. QHPs that are accredited by a national accreditation entity that HHS has determined uses standards at least equivalent to the NAIC Model Act should be given "deemed" status as meeting the national minimum 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 422.1129(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. These categories may also be useful for defining the geographic service areas in regional exchanges or exchanges that cross state lines.

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.

Potential additional requirement regarding access and availability of providers

The proposed rule also seeks comment on a potential additional requirement that the Exchange establish specific standards under which QHP issuers would be required 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. Many state licensed and accredited health plans already have Quality Improvement (QI) programs that are responsible for assuring that these types of requirements are in place and monitor compliance with these standards on an ongoing basis.

Recommendation: As noted above, HHS should include these additional requirements from the NAIC Managed Care Plan Network Adequacy Model Act as part of minimum national network adequacy requirements for QHPs. Where state licensure requirements or national accreditation entities have adopted requirements that are at least equivalent, QHPs may be deemed in compliance with these additional requirements if they are licensed in good standing and/or accredited.

Scope of Network Standards

The preamble seeks comment on an additional standard 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. Under this standard, QHPs should also be required to address the cultural needs of its enrollees, such as by providing access to

multilingual practitioners or interpretation services. The preamble suggests mechanisms of achieving this goal, such as by using telemedicine and broadly defining providers (including through the use of nurse practitioners for primary care delivery).

Recommendation: HHS should adopt 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."

Out-Of Network Providers

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. In a number of situations the provider is not willing to be a participating provider in a health plan network. In other situations, the provider may not be willing to 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. To add to the confusion, the enrollee's physician or surgeon and the hospital may be participating providers, but other providers involved in the enrollee's treatment are not and the enrollee finds out after the treatment that certain providers are not participating. The end result is that enrollees incur significant unplanned financial costs because a participating practitioner or facility is not available. A health plan process to assist enrollees prospectively in identifying the participation of providers and either finding accessible participating providers or helping to negotiate the fees from non-participating providers would be extremely helpful.

Exchanges should also incorporate provisions in their network adequacy requirements to address access to centers of excellence for certain tertiary or specialized care that may not be available within the geographic service area of the QHP or the Exchange. For example, a child born with severe congenital heart defects may need access to a pediatric cardiologist and a children's hospital that may not be available within the area of the Exchange.

Such a requirement is included in the NAIC's Managed Care Plan Network Adequacy Model Act. In addition, the Contract Year 2012 Medicare Advantage Health Services Delivery Guidance section II. Overview of MA Network Adequacy Criteria A. Minimum Number of Providers contains the following provision that should be incorporated into the proposed regulation:

> "Hospital-based providers: The specialty types of Anesthesiology, Pathology, Radiology, Critical Care Medicine, and Emergency Room physicians are not included on the 2012 HSD Provider Table. MA applicants are expected to ensure that all Medicare–covered services rendered to beneficiaries during an admission to a contracted hospital are covered at the in-network benefit level and cost sharing".

Recommendation: 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 should be adopted.

§155.1055 Service area of a QHP

It is reasonable to give Exchanges the flexibility to determine service areas for Exchange plans. A state-operated Exchange, in particular, is likely to be well-positioned to draw the appropriate service area boundaries based on market characteristics, ensure that service areas do not prompt discrimination against certain types of beneficiaries, and take into consideration the service areas in the markets outside an Exchange in order to avoid disparities that could lead to adverse selection.

We oppose leaving the decision about service areas to insurers' discretion. We recognize that insurers decide may decide their own service areas in many states today. But once (per the ACA) insurers must accept all enrollees regardless of health status and are more limited in the ways they can price plans to take into account health status and other factors, some insurers may turn to other tactics to limit their exposure to high-cost beneficiaries. They may seek to avoid serving areas where beneficiaries are likely to be more costly or use more services. Exchanges must meet the requirement to ensure that QHP service areas are established without taking into account health status, claims experience, and other factors as required under §155.1055(b) of the proposed rule. To do this, the rule must be strengthened so that Exchanges are required to proactively establish the appropriate, largely consistent service areas for QHPs.

The service areas established by 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 could have greater ability to pick and choose the areas where they will offer their products, possibly in ways that help avoid sicker, high-cost enrollees. If a state is operating its Exchange, it should apply the service areas for QHPs to the outside market.

One way for Exchanges to achieve consistency in QHP service areas is to establish them based on 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. We have commented previously that HHS should establish clear rules and procedures that require states to justify separate rating areas by demonstrating significant geographic differences in health care spending, utilization, and the level of insurer and provider competition. 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 the pre-determined service areas it sets, 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. We also support the requirement at §155.1055(a) of the proposed rule to require QHP service areas to be at least the size of a county, with an ability for the Exchange to grant exceptions.

Recommendations: Require Exchanges to have a process to establish the service areas for QHPs, with the discretion for an Exchange to allow a plan to deviate from the pre-determined boundaries in cases where it is necessary, not discriminatory and in the best interest of qualified individuals and employers. Exchanges should also be required to take into account the rating areas established in a state when determining QHP service areas and to ensure as much as possible that that service

§155.1075 Recertification of QHPs

Recertification Process, §155.1075(a)

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.

Timing, §155.1075(b)
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.

§155.1080 Decertification process for QHPs

Decertification Process, §155.1080(b)
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.

Decertification by the Exchange, §155.1080(c)

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. If plans fail to do so, exchanges must be *required* to remove their QHP certification and cease to include them in the exchange. Otherwise, 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.

Appeal of Decertification, §155.1080(d)

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.

Notice of Decertification, §155.1080(e)

We support the provision of the rule stating that enrollees in a QHP that has been decertified must receive notice of a special enrollment period and be granted the same enrollment opportunities as other individuals who qualify for special enrollment. However, 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 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, Subpart A – General Provisions

§156.050 Financial support

In §156.050(b), the proposed rules require that any participating issuer must remit user fee payments assessed by an Exchange used to finance Exchange operations. According to the preamble, participating issuers would 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 or Exchange-related operations. We strongly support this broad definition because it would allow, for example, financing for a variety of purposes related to the Exchanges. The proposed rules, however, in §156.050(a) do not use such a broad definition and limits the definition to "any issuer offering plans that participates in the specific function that is funded by user fees." A more appropriate wording would be "any issuer offering plans that is affected by Exchange functions or other activities related to the Exchange."

In addition, under §156.050(b), the requirement that plans pay the assessments that are charged to them only discusses user fee payments assessed by an Exchange. It should include any assessments or similar payments or charges that are used to provide funding for ongoing operations of an Exchange under §155.160. The proposed rules at §156.050(b)

should be amended to read: "A participating issuer must remit user fee payments assessed by an Exchange or any other fees, charges or payments required by the State to provide financial support for continued Exchange operations under §155.160.

Recommendation: The proposed rules should be modified to provide a broad definition of participating issuers required to pay Exchange fees and require remittance for user fees as well as any other payment related to financing Exchange operations on an ongoing basis.

Part 156, 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 scaled back certain benefits used primarily by sicker individuals, for example by charging much higher copayment charges for days in the hospital or costly treatments like chemotherapy compared to traditional Medicare fee-for-service.[v] QHP issuers may have even greater leeway that 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 the number and resolution of 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 plan 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.

§156.220 Transparency in coverage

See §155.1040.

§156.225 Marketing of QHPs

General comments

We first note that the proposed rules at §156.225(b) codify the statutory requirement included in section 1311(c)(1)(A) of the Affordable Care Act that QHPs do not employ marketing practices that discourage the enrollment of individuals with significant health needs. In a glaring omission, however, the proposed rules do not anywhere codify the additional requirement under section 1311(c)(1)(A) that QHPs are not permitted to 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 the proposed rules at §156.200.

We strongly support strong marketing standards for QHPs and believe such standards will be critical not only to protecting consumers but also to building public confidence in the Exchange and among issuers who wish to enter this market. Exchanges will serve many consumers who have little experience with buying health insurance in the commercial market, and marketing requirements should be crafted with their needs in mind. Many individuals who will qualify for premium subsidies and thus seek coverage in the exchanges may have been uninsured for long periods of time, may be more familiar with Medicaid and other public programs, or may be accustomed to more limited choices of benefits and plan design under prior employer-sponsored coverage.

In order to guard against the unfair marketing of QHPs, we believe the marketing standards in the final rule should go further than the proposed rule in two main ways. First, there are certain problematic marketing practices that have occurred with enough regularity, and which are only employed for the purpose of selectively enrolling cheaper-to-cover populations, that federal standards should prohibit them outright. Second, as part of its state plan, each Exchange should be required to detail how they will monitor the marketing practices of QHPs so as to ensure that discriminatory marketing practices do not proliferate.

§156.225(a) – State law applies

In general, we agree with the proposed rule that issuers should have to comply with state law in order to be certified as a QHP and that states are best positioned to regulate their marketing practices. Recent experience in Medicare Advantage — where CMS rather than state regulators assumed oversight responsibilities — showed the dangers of not giving state regulators enough oversight of their insurance markets. In the years after the passage of the Medicare Modernization Act consumers complained about long wait times when they attempted to contact Medicare with a complaint about their plan and about having to wait for weeks to receive a response.[v]

§156.225(b) – Non-discrimination

We believe the best way to prevent discriminatory marketing practices by QHPs is for HHS to employ a two-pronged approach. First, in addition to a broad prohibition against unfair or deceptive marketing practices, certain tactics have been abused with enough regularity that they should be prohibited outright. Second, each state Exchange plan should include a section that details the anti-discrimination standards the Exchange will adopt and how it will ensure compliance with those standards.

Certain discriminatory or misleading marketing practices have occurred with enough regularity that the final rules should ban them outright across all exchanges. These include the distribution of 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. These recommendations are informed by experiences with Medicaid managed care and Medicare private market 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 amounts. In Medicare Part D, agents were allowed to cross-brand private insurance products, such as life insurance products. The Medicaid managed care plan rules prohibit many of these tactics.

The second step in limiting discriminatory marketing practices on the part of QHPs is to require each Exchange to submit as part of its state plan a section that outlines the compliance and enforcement powers it will adopt.[v] For compliance, 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 state plan. 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 would include consumer education seminars, programs to contact consumers after they have purchased a plan to confirm they are enrolled in the plan they think they purchased, and the establishment of a dedicated hotline or web portal for consumers wishing to lodge a complaint against a QHP. We believe exchanges should 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 Web site 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.

For enforcement, the Exchange should outline how it will deal with QHPs suspected to have engaged in unfair or discriminatory marketing practices. This could include the powers of the Exchange or a state regulator to fine or otherwise penalize the issuer of a QHP found to not be operating in the public interest, including by decertifying the plan as an Exchange QHP or revoking the state's license to the issuer to offer coverage in the state. Exchanges should also develop a process by which they will ensure that QHPs found to have been noncompliant but still offering coverage in an Exchange will change their marketing behaviors. For the most severe cases involving issuers who wish to continue to offer their plans in the exchange, the exchanges should require them to develop and follow a corrective action plan to ensure they adhere to marketing rules going forward.

We agree with the preamble that States should ensure that all health insurance issues offering coverage in the individual and small group markets meet these same strengthened marketing requirements in order to create a level playing field with equal robust consumer protections inside and outside the exchange.

§156.230 Network Adequacy Standards

In paragraph (a), the rule describes the general criteria for network adequacy that health plans must meet to be certified as QHPs, pursuant to section 1311 (c)(1)(B) of the ACA and consistent with the requirements being proposed under §155.1050. According to the preamble, certified QHPs must also provide information to potential enrollees on the availability of in-network and out-of-network providers. In paragraph (b) the rule proposes that a QHP issuer "must make its health plan directory available to the Exchange electronically and to potential enrollee and current enrollees in hard copy upon request."

Network adequacy criteria for QHPs

§156.230(a) of the proposed rule requires QHPs to comply with "any network adequacy standards established by the Exchange consistent with §155.1050. In our comments pertaining to $155.1050, we made a number of recommendations for ensuring that these requirements are meaningful network adequacy standards for QHPs, and we reiterate those recommendations here.

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 have a sufficient choice of providers accepting their health plan to meet the minimum national network adequacy standards. QHPs that are accredited by a national accreditation entity that has standards at least equivalent to the NAIC Model Act (as determined by HHS) should be given "deemed" status as meeting the national minimum network adequacy standards. In addition, HHS should adopt the Medicare Advantage approach and criteria for determining network adequacy as the minimum qualitative or quantitative standards for determining that a QHP has sufficient numbers and types of providers to provide access to covered services.

Access to QHP directories

According to the preamble, "Exchanges will have discretion to determine the best way to give potential enrollees access to the provider directory for each QHP, including through a link from the Exchange's Web site to the issuer's Web site, or by establishing a consolidated provider directory through which a consumer may search for a provider across QHPs." The rule itself requires QHP issuers to "make its provider directory for a QHP available to the Exchange for publication online pursuant to guidance from the Exchange and to potential enrollees in hard copy upon request." We strongly agree that the provider directory should be accessible to enrollees and potential enrollees, and we support allowing Exchanges to have discretion to determine the best way to give potential enrollees access to the provider directory for each QHP as part of the minimum national standard.

Many states already allow health plans to provide provider directories electronically on their website and make hard copies available upon request. National accreditation entities

also have health plan standards that require a process for providing enrollees or potential enrollees with access to the provider directory electronically, through a paper copy or by telephone. Some health plans also have processes on their website to create and print "customized directories" based on the geographic location of the enrollee and the types of providers and facilities that they wish to receive information about. Individuals that do not have access to the Internet may request hard copies of the directory or a portion of the directory by contacting Member Services.

To assist enrollees in accessing providers, many health plans currently post and update the names of participating providers and facilities on their website and will be making this information available on the Exchange website. Health indemnity plans should also be required to make available to the Exchange updated names of providers and facilities accepting their coverage.

When determining how best to make provider directories available to enrollees and potential enrollees, 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 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.

Recommendation: We support the requirement that a QHP issuer must make its health plan directory available to the Exchange electronically and to potential and current enrollees in hard copy upon request. In allowing Exchanges to have discretion in determine the best way to give potential enrollees access to the provider directory for each QHP, the final rule should ensure that they be required to address the needs of enrollees and potential enrollees with diverse cultural and ethnic backgrounds, limited English proficiency, and physical and mental disabilities.

<u>Identification of providers not accepting new patients and updating of directory</u>

§156.230(b) of the rule also requires that "In the provider directory, the QHP issuer must identify providers that are not accepting new patients." HHS indicated that it is seeking comment on "standards we might set to ensure that QHP issuers maintain up-to-date provider directories."

We support requiring the QHP issuer to identify providers that are not accepting new patients or are no longer part of the network on a quarterly basis as a minimum standard. QHPs that are indemnity health plans should similarly be required to update the names of providers and facilities accepting their coverage on a quarterly basis. In addition, the electronic and paper provider directories should include educational language advising an enrollee or potential enrollee to call the provider or facility to confirm that the provider is

still participating in the QHP and accepting new patients before seeking care to avoid potential situations where the care will be out-of-network with higher cost sharing.

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

Recommendations: We support requiring QHP issuers to update their directory on a quarterly basis to identify providers that are not accepting new patients or are no longer part of the network as a minimum national standard.

§156.235 Essential community providers

As noted in the proposed rule, section 1311(c)(1)(C) of the ACA requires that health plans participating in state-based exchanges must contract with essential community providers (ECPs) including women's health centers, HIV/AIDS clinics, community health centers, and public hospitals that serve medically under-served and low-income populations. This provision establishes a critical protection to ensure that newly insured patients can access the primary and preventive care they need from providers in their communities. It is also vitally important for racial and ethnic minorities who, compared to Whites, have less access to medical care. Ensuring that consumers in the exchanges have access to ECPs will help ensure continuity of care for those recently uninsured who currently receive care from these providers, as well as those who transition off Medicaid because of income fluctuations. It can also help with outreach and enrollment efforts among low-income populations and those who face cultural and linguistic challenges in accessing care.

In addition, these providers can help address expected primary care workforce shortages and help address disparities in access to care among communities of color. Ensuring access to ECPs not only helps increase the number of primary care providers, it can also help expand the geographic availability of providers. ECPs often work in publicly funded clinics that are strategically located to promote easy access for traditionally under-served populations. Whether clinics are located in low income urban neighborhoods, rural or remote areas or near public transportation, providers serving in these clinics are accustomed to meeting the special needs of low-income populations – and that includes making sure that they have easy access to affordable health services. We were very pleased that the Department adopted a broad definition of essential community providers that will make it easier for all women and families to access the care that they need.

The proposed rule requested comments on how to ensure that there are a sufficient number of ECPs. In order for the provision to have its intended impact, it is imperative that HHS implement the ECP protection in a meaningful and robust way so that patients are guaranteed access to the providers they trust in their communities. We recommend that

the Department ensure that all potential providers are included in the definition. Specifically, the regulations should be amended to ensure that all the ECPs Congress intended are protected by the provision, including Title X family planning clinics and women's health centers.

Given the unique health care access needs of women, it is especially important that HHS emphasize the importance of requiring exchange-participating health plans to contract with family planning clinics or women's health centers. Reproductive health clinics serve a wide array of men, women, and children and provide numerous important health services. For many women, these clinics are their only source of health care. It is crucially important that abortion providers not be disqualified from being ECPs simply because they provide a legal, constitutionally protected health service. We also encourage the Department to include school-based health centers (SBHCs) in the definition. SBHCs provide vital primary care services to children and adolescents and for many young people may be their only or primary source of health care.

Recommendation: We urge HHS to adopt broad contracting requirements that require QHP issuers to offer a contract to all essential community service providers in the service area on an "any willing provider" basis. This will ensure that women and families have improved access to ECPs and do not have to find new providers. Furthermore, to achieve the true intent of the provision – which was to ensure strong access points –HHS should require that health plans contract with ECPs for the full range of services offered by the plan. In addition to providing more efficient and patient-centered care, such a requirement would also support better continuity and coordination of health care – top tenets of the ACA.

Finally, in our current delivery system, a vast majority of low-income consumers receive care through Federally-Qualified Health Centers (FQHCs); however, FQHC providers do not always have board certification. While the goal is for exchanges to use the highest-quality providers and encourage increased board certification, exceptions should be available to ensure that the providers upon whom low-income consumers rely upon are not crowded out of this new coverage model.

§156.245 Treatment of direct primary care medical homes

<u>Encouraging the Use of Patient-Centered Medical Homes</u>
The implementation of the patient-centered medical home concept could profoundly advance health care in this country, both by improving the quality of care patients receive and experience and by reducing costs. A patient-centered medical home provides care in a different way than most primary care practices do. The practice organizes care around the patient and his or her care, and emphasizes care coordination, patient self-management support, and continuous quality measurement and improvement. This results in better patient experiences with care and brings significant health and cost benefits, including

greater attention to prevention and wellness, more care coordination, reduced health disparities, and fewer hospitalizations.

We strongly endorse the integration of patient-centered medical homes into QHPs. Exchanges should leverage a range of tools to encourage use of patient-centered medical homes, such as reporting requirements that call for the percentage of primary care providers in a plan's network that are part of a recognized patient-centered medical home and, eventually, the percentage of primary care services provided by a patient-centered medical home. QHPs should be allowed and encouraged to use payment incentives such as a network tiering policy that makes patient-centered medical homes available at a lower level of cost-sharing or tying payment rates to providers to their performance on measures relevant to patient-centered care. Consumers should be educated about the benefits afforded by a patient-centered medical home.

Recommendation: Exchanges should leverage a range of tools to encourage the integration of recognized patient-centered medical homes into QHP networks and not be limited to direct payment arrangement described in the proposed rule.

Standards for Direct Primary Care Medical Homes

In §156.245, the proposed rule contemplates the inclusion of *direct primary care medical homes* within Exchanges. The proposed regulation defines a direct primary care medical home plan as an arrangement where a fee is paid by an individual, or on behalf of an individual, directly to a medical home for primary care services (routine heath care service, including screening, assessment, diagnosis, and treatment for the purpose of promotion of health, and detection and management of disease or injury). The Department also is soliciting comments on specific standards the Secretary should establish to determine whether a practice or clinic qualifies as a direct primary care medical home.

First and foremost, the standards should specify that all direct primary care medical homes must be officially recognized as a patient-centered medical home by an accrediting organization, such as URAC, NCQA, or the Joint Commission, or under state law. Indeed, without this recognition, a QHP should be prohibited from marketing itself as offering a medical home. Today there is a well-developed, broadly accepted body of standards that are associated with the term medical home and consumers can be misled if the providers offered by the QHP do not meet those standards. These criteria include:

- An interdisciplinary team guides care in a continuous, accessible, comprehensive and coordinated manner.
- The patient-centered medical home takes responsibility for coordinating its patients' health care across care settings and services over time, in consultation and collaboration with the patient and family.
- The patient has ready access to care.

- The patient-centered medical home "knows" its patients and provides care that is whole person oriented and consistent with patients' unique needs and preferences.
- Patients and clinicians are partners in making treatment decisions.
- Open communication between patients and the care team is encouraged and supported.
- Patients and their caregivers are supported in managing the patient's health.
- The patient-centered medical home fosters an environment of trust and respect.
- The practice continually monitors its performance on both clinical and patient experience measures.

Recommendation: HHS should establish a set of criteria for direct primary care medical homes that requires direct primary care medical homes to be officially recognized as a patient-centered medical home by an accrediting organization, such as URAC, NCQA, or the Joint Commission, or under state law, thus ensuring that the direct primary care medical home meets a number of key principles integral to patient- and family-centered care.

Additional Requirements

Together with establishing robust criteria to ensure that all direct primary care medical homes are truly patient-centered, it is important to consider how this model, with its unique financial arrangement, will be integrated into QHPs. We strongly support HHS's decision that QHPs providing coverage through direct primary care medical homes must still meet all QHP requirements that are otherwise applicable. The use of direct primary care medical homes should not in any way allow plans to eschew the rules and regulations governing QHPs, such as network adequacy requirements.

The proposed rule also requires that QHPs must coordinate covered services with the direct primary care medical home. HHS should elaborate on this requirement, which could have two different components. The first component is ensuring that plans offering direct primary care medical homes are covering the full essential health benefit package and that the ten categories of benefits are appropriately balanced and not unduly weighted towards any category per §1302(b)(4)(A) of the ACA. Exchanges should closely monitor the benefit packages of plans offering direct primary care medical homes to ensure they are balanced and do not risk adverse selection.

The second component is coordinating the delivery of services to patients. As noted previously, care coordination is a critical part of patient-centered medical homes. QHPs should be encouraged to think about how they can facilitate care coordination between providers inside and outside of the direct primary care medical home. One important way to accomplish this would be to invest in health IT. For instance, a QHP could provide payment incentives to providers that adopt and meaningfully use certified electronic health records (EHRs). QHPs should also consider leveraging information sharing arrangements, such as providing prescription drug data to primary care providers.

Recommendations: HHS should elaborate on the requirement that QHPs must coordinate covered services with the direct primary care medical home to address two distinct goals: 1) ensuring that plans offering direct primary care medical homes are covering the full essential health benefit package and that the ten categories of benefits are appropriately balanced; and 2) facilitating care coordination between providers inside and outside of the direct primary care medical home, such as by making investments in or providing payment incentives to providers that adopt and meaningfully use certified EHRs.

Integrating Direct Primary Care Medical Homes in QHPs

In the preamble, HHS notes that it rejected allowing an arrangement wherein a consumer can purchase a direct primary care medical home plan and separately acquire wrap-around coverage. We strongly support this decision. Such an arrangement would significantly complicate the process of ensuring the consumer has access to the full EHB package and allocating premium tax credits, as well as certifying that the individual has satisfied the minimum essential coverage requirements.

However, we encourage HHS to provide further guidance on how direct primary care medical homes will interact with QHPs and offered in the Exchange. It is important that such plans offer seamless coverage to consumers – the direct primary care medical home plan should be fully integrated into the QHP. Consumers should only be required to make a single premium payment, with any payments for the medical home being segregated from the rest of the premium on the back end by the QHP. Consumers should not have to pay any additional fees beyond their premium for services offered by the direct primary care medical home plan (e.g. a monthly copay or other cost-sharing arrangement).

Recommendation: HHS should specify that consumers should only be required to make a single premium payment for a QHP offering a direct primary care medical home and should not be subject to any additional fees for services offered by the medical home.

§156.250 Health plan applications and notices

See §155.230.

§156.275 Accreditation of QHP Issuers

General Requirement, §156.275(a)(1)

The proposed rule requires QHP issuers to be accredited on the basis of local performance of its QHPs in a number of categories by an accrediting entity recognized by HHS. 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 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.

Recommendations: HHS-recognized accrediting bodies must require plans to report 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 maintain network adequacy standards that are at least equivalent to the NAIC's Managed Care Plan Network Adequacy Model Act.

General Requirement, §156.275(a)(2)

The proposed rule also requires QHP issuers to authorize the accrediting entity to release to the Exchange and HHS a copy of its most recent accreditation survey, together with any survey-related information that HHS may require, such as corrective action plans and summaries of findings.

Consumers and purchasers of care want and need to know about health plan quality and level of accreditation. We strongly support this requirement and encourage HHS to require Exchanges to publish consumer-friendly accreditation information on their Internet Web sites, 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). If QHPs are not yet accredited, this should be

reported, along with information on what accreditation means. QHPs' HEDIS and CAHPS scores should also be posted on Exchanges' Internet Web sites.

Recommendation: Exchanges should be required to publish consumer-friendly accreditation and quality information on their Internet Web sites for all accredited QHPs. If QHPs are not yet accredited, this should be reported.

Time frame for accreditation, §156.275(b)

The proposed rule requires a QHP issuer to be accredited within the timeframe established by the Exchange in which they are operating. Instead, we encourage HHS to set a universal timeframe for all Exchanges to minimize burden on states, as well as QHP issuers operating across jurisdictions. This grace period should be no longer than one year, unless QHP issuers can document extenuating circumstances for the delay.

Recommendation: QHP issuers must be accredited no later than one year after certification.