CONSUMER REPRESENTATIVES TO THE
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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

RE: Proposed Rule: Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans, CMS–9989–P

Dear Secretary Sebelius:

We are writing as consumer representatives, appointed by the National Association of Insurance Commissioners to represent millions of American health insurance consumers and patients, to comment on proposed regulations for establishing the American Health Benefit Exchanges, which will be created under § 1311 and §1321 of the Affordable Care Act. Many of us represent organizations that will be separately submitting their own comments on the proposed regulations. These comments are not intended to be comprehensive but rather are intended to supplement comments submitted by our own and by other consumer organizations. They do address issues, however, of particular concern to insurance consumers.

Partnership Model, Preamble to Proposed Rule

We understand the need for state flexibility and applaud HHS for seeking ways for the federal and state governments to collaborate on developing robust Exchanges. HHS recently provided greater detail about potential options for federal-state Partnerships at a State Exchange Grantee Meeting. We are continuing to analyze the options that were presented. Overall, we support HHS' effort to place clear parameters around the Partnership concept and to ensure that the experience for consumers is seamless. We also support the position, consistent with the statute, that HHS is ultimately responsible and accountable for "Partnership" Exchanges even if a state handles certain aspects of consumer assistance and/or health plan management functions.

Recommendations:

As HHS continues to develop the Partnership approach, we recommend that HHS:

- Ensure through regulation that the Partnership approach is clearly defined.
- Ensure that any state working with HHS on a Partnership is subject to robust readiness standards and that a contract is established to clearly define state roles and responsibilities.
- 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.

- Ensure that any Partnerships that are established meet the goals of increasing efficiency, reducing redundancy, and providing consumers with a seamless, one-stop shop for the consumer, as measured by objective standards.
- Clarify that HHS is ultimately responsible for the performance of any contractors utilized by an Exchange operated under a Partnership, including by approving use of such contractors and ensuring that they meet applicable requirements.
- Clarify through regulation that certain functions of an Exchange are not appropriate for a Partnership. For example, we would be concerned about whether seamlessness for consumers could be achieved if states could leave Exchange eligibility and enrollment functions to the federal government.

Entities Eligible to Carry Out Exchange Functions, §155.110

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.

Recommendations:

With respect to entities eligible to carry out Exchange functions, we recommend that the rule:

- Require Exchange governing boards to prohibit membership of individuals with a clear conflict of interest.
- Explicitly define an individual with a clear conflict of interest as an individual whose income or revenues are based in whole or part, directly or indirectly, on the cost or volume of health insurance sold (e.g., health insurance issuers, insurance agents, brokers and providers). 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.
- If HHS intends to ensure that Exchange governing boards predominantly represent consumer interests, and if it ultimately permits conflicted parties to serve on Exchange boards (which we oppose), then the rule should explicitly:
    - Require more representatives of consumer interests than conflicted voting members, and
    - Require consumer interests to constitute an overall majority and a voting majority of the board.
- Harness the expertise and knowledgeable of conflicted parties, such as insurers and brokers, through other formal, non-governing channels, such as a robust stakeholder consultation process, rather than allowing them to serve on the board.
- Be more explicit about the policies on ethical practices and conflict of interest that Exchanges must meet.
    - We commend to you the NAIC's own conflict of interest policy as a model for a policy that should be adopted by the federal rules governing Exchanges: http://www.naic.org/documents/about_conflict_of_interest_policy.pdf
- Require HHS to review the accountability structure and governance principles of Exchanges. 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).

Initial and Annual Open Enrollment Periods, §155.410

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 open enrollment notices, and the use of auto-enrollment in certain limited circumstances.

Recommendations:

With respect to initial and open enrollment periods, we recommend that the rule:

- Extend the initial enrollment period from February 28, 2014, to the end of March 31, 2014, to allow additional time to outreach to, and educate families about, their coverage options.
- For QHP selections made between January 1, 2014, and March 31, 2014, coverage should be effective on the 1st of the following month.
- Require a 30-day notice before the start of each annual enrollment period and require a reminder notice to be sent to all consumers 30 days before the close of the open enrollment period. Both notices should include important information about options for coverage and the implications of being uninsured. To the extent that the consumer has identified their primary language as other than English, these notices should be issued in that language. In anticipation of and during the open enrollment period, these notices should be accompanied by a broad-based public information campaign to a general audience.[1]
- Change the annual open enrollment period from October 15 through December 7 to October 15 through December 15.
- Allow auto-enrollment in very limited circumstances (e.g., when a person receiving a premium credit is in a plan that is being decertified or is no longer available) and provide individuals who are auto-enrolled a limited period (perhaps 60 days) from the time they are auto-enrolled to change plans without cause. Prior to any auto-enrollment, Exchanges should be required to make every effort to provide clear and sufficient notice to individuals about the need to make a QHP selection.

Special Enrollment Periods, §155.420 and §156.285

Section 155.420 establishes special enrollment periods for Individual Exchanges, and § 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 are allowed to change tiers of coverage, at least in some situations.

Recommendations:

With respect to special enrollment periods, we recommend that the rule:

- Allow special enrollees the option of having, as the date of their special enrollment coverage, the date that they lost other coverage, provided they pay premiums back to that date. This will prevent enrollment gaps. 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.
- 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.

[1] For this approach, Exchanges can draw from two established models where consumers elect coverage and cost sharing options and choose provider networks--the Federal Employees Health Benefit Program (FEHBP) and Medicare Advantage.

- Clarify that a person losing any source of minimum essential coverage is entitled to special enrollment. 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 alters an eligibility determination regarding premium credits or cost sharing reductions begins a special enrollment period .
- Add special enrollment periods for people reaching the COBRA disability extension period and for people leaving incarceration.
- Delete the prohibition on changing tiers of coverage during a special enrollment period.
- Add a new subsection on special enrollment notice. Specifically:

    - Require Exchanges to notify people of their special enrollment rights when they report an income change or other life change that would trigger special enrollment.
    - Require Exchanges to provide all new enrollees and applicants with general information about special enrollment periods and require them to include information about special enrollment rights on their websites.
    - Require COBRA notices to include information about special enrollment in Exchanges. Direct employers that are terminating group plans or reducing or eliminating their contribution to group plans to notify enrollees that they may be entitled to special enrollment. Require Medicaid/CHIP agencies to notify people of their possible Exchange eligibility and special enrollment rights prior to the end of the eligibility period.

Transparency in Coverage, §155.1040 and § 156.220

The proposed rule 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 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.

Recommendations:

With respect to transparency in coverage, we recommend that the rule:

- Require Exchanges to collect transparency information annually from QHPs, either before or when a QHP seeks certification or recertification, and define an enforcement process that ensures timely completion of reporting requirements.
- Require issuers to provide at least the same transparency information that is available on a public website directly to a consumer in a timely manner upon request.
- 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.
- Align cost-sharing information requirements with similar requirements in the proposed rule on Summary of Benefits and Coverage and the Uniform Glossary.
- Establish uniform standards and methodologies for reporting required data to facilitate compliance and ensure issuers 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.

Required Consumer Assistance Tools and Programs, §155.205

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 on their own (via the website or kiosks, via Exchange-provided "assistors" (e.g., call centers) 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.

Recommendations:

With respect to consumer assistance tools and programs, we recommend that the rule:

- Require each state 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.
- Have § 155.205(d), which describes the requirement to have a consumer assistance function, be the lead into § 155.205 of the regulation, as the other topics in this section are forms of consumer assistance.
- Expand the regulatory language to more fully describe the complete scope of consumer assistance functions, the "doorways" (such as telephone hotlines) for receiving consumer assistance and the standards and performance measures to ensure a uniformly successful consumer experience, regardless of the doorway used. Also, ensure that all Exchange-provided consumer assistance is uniform, responsive, timely, and accurate.
- With respect to the desirability of avoiding duplication of consumer assistance functions between Exchange and non-Exchange entities, 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.
- Add the following data items to those that must be included on the Exchange web site:
    - Health plan drug formulary information.
    - Medical and insurance terms consistent with the Summary of Benefits and Coverage and the glossary of medical and insurance terms.
    - 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.

- With respect to the rule that invites comment on whether healthcare.gov could serve to fulfill the requirement for HHS under § 1311(c)(5) of ACA to provide a model template for Exchanges, do <u>not</u> allow Healthcare.gov to serve as the HHS-provided model template for Exchange websites. The Exchange website will be not only an informational but also a transactional site. Accurate premium and out-of-pocket costs (reflecting any subsidies) are of primary interest to consumers.
- Require HHS to 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.
- Amend §155.205(e) to require 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.

- 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.
- Require Exchanges to 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.
- Require Exchanges to use Exchange performance data to identify any populations which appear to be underserved and target additional, effective outreach and educational activities to such groups.

Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Employers, and Employees Enrolling in QHPs, § 155.220

While different states may come to different conclusions about brokers' 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.

With respect to agents and brokers assisting qualified individuals, employers and employees in QHPs, we recommend that the rule:

- Add new paragraphs 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 consumer's best interest.
  - 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.

- Add a new subparagraph under §155.220(b) requiring the display of broker fees and, alongside agent and broker information, enrollment options other than through agents and brokers.
- If an agent or broker is found to be steering enrollees or violating other rules, prohibit him/her 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 engaging in enrolling in the Exchange should be listed as well.

Navigator Program Standards, §155.210

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.

Recommendations:

With respect to Navigator program standards, we recommend that the rule:

- Consider additional requirements to ensure that Navigator programs have sufficient capacity to serve all individuals and small businesses in need of assistance.

- Include the following:

    - Specify the process by which Exchanges must assess whether potential Navigators have or can form relationships with Exchange-eligible consumers and businesses.
    - Expand the conflict of interest requirements for Navigators.
    - Maintain the requirement that each Exchange have Navigators representing at least two different eligible entities and specify that at least one of those entities must be a community or consumer-focused nonprofit organization. Exchanges should enlist the involvement of organizations that have a history of helping groups with low English proficiency, remote access challenges in rural areas or represent people with disabilities in terms of alternate communication formats and/or have physical access limitations.
    - 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.
    - Require Navigators to be knowledgeable in both public programs and the private insurance market.
    - Require HHS to develop a model training and certification program for Navigators that Exchanges can adapt to include state-specific information.
    - Prohibit Exchanges from requiring Navigators to carry errors and omissions coverage but require them to have liability coverage.

- Add to §155.210 a description of a federal oversight process for Exchange Navigator programs that:

    - Specifies that Navigator duties include providing accurate information on both public and private coverage programs.
    - Describes with greater specificity the requirement that Navigators provide information and services in a "fair, accurate, and impartial manner"
    - Specifies that Navigators must meet the same standard as the Exchange regarding the provision of culturally and linguistically appropriate information, including complying with both Title VI of the Civil Rights Act and § 1557 of the ACA.

- Specify that HHS will monitor Navigator programs to ensure that they have sufficient funding to meet the needs of all potential Exchange enrollees.
- Require Exchanges to have Navigator programs fully operational by the first day of the initial Exchange open enrollment period.

Marketing of QHPs, §156.225

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.

Recommendations:

With respect to the marketing of QHPs, we recommend that the rule:

- Codify the additional requirement under § 1311(c)(1)(A) that QHPs are not permitted to offer *benefit designs* that have the effect of discouraging enrollment by individuals with significant health needs.
- Prohibit marketing practices that are only employed for the purpose of selectively enrolling cheaper-to-cover populations. 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.

- Require Exchange Plans submitted by states to:
    - Detail how the Exchange will monitor the marketing practices of QHPs so as to ensure that discriminatory marketing practices are not used.
    - Describe the anti-discrimination standards the Exchange will adopt and how it will ensure compliance with those standards.
    - Include a section that outlines the compliance and enforcement powers it will adopt.
    - Outline how the Exchange will deal with QHPs suspected of engaging in unfair or discriminatory marketing practices.

Thank you for considering our recommendations.

Sincerely,

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