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Submitted electronically: FFEcomments@cms.hhs.gov

Re: Letter to Issuers on Federally-facilitated and State Partnership Exchanges — AHIP Comments

AHIP provides these comments in response to the Center for Consumer Information and Insurance Oversight (CCIIO) of the Centers for Medicare and Medicaid Services (CMS) Letter to Issuers on Federally-facilitated and State Partnership Exchanges (the "Letter") released on March 1, 2013. As requested, we have organized our comments by the subsections of the Letter.

This guidance supports the operations of the State Partnership Exchanges and Federally-facilitated Exchanges (FFE) and provides helpful distinctions on where the operation of those may differ. We appreciate that much of the information contained in the letter is a useful compilation of discussions and other guidance already released. Our comments therefore focus on new areas of concern, or items of potential risk to the smooth implementation of the Exchanges. This is particularly important because the time remaining to stand up the Exchanges is telescoping dramatically - there is no room for failure, and little room for mistakes. We understand the critical timelines and make suggestions where we believe flexibility or adjustments are needed to ensure success.

Chapter 1: Certification Standards for QHPs

Section 1. Network Adequacy and Inclusion of Essential Community Providers

i. Network Adequacy

We recommend that CMS accept state determinations of sufficient network adequacy in those states with sufficient adequacy reviews, given the short timeframes for compressed review and approvals. This is affirmatively stated in the opening paragraph in this section – "*As a result, for the 2014 coverage year, when CMS is evaluating applications for QHP certification, CMS will rely on state analyses and recommendation when the state has the authority and means to assess*

issuer network adequacy." Attestations by issuers and states should serve to demonstrate that traditional network adequacy standards have been met.

ii. Essential Community Providers

We appreciate the ability for issuers to write in ECPs not on the CMS-developed list and that allowable write-ins will count toward the satisfaction of the minimum expectation or safe harbor standard (i.e., count towards the percentage threshold). Issuers will be working over the coming months to continue to add ECPs to their networks.

We recommend that issuers be afforded an opportunity to upload an updated ECP template later this summer to account for any additions since the April submission window. We also note that issuers should be permitted to update networks following the submission window of QHP applications, since networks are dynamic and regularly grow and change and there have been delays in providing the ECP list to health plans.

We appreciate the ability for issuers to write in ECPs not on the CMS-developed list and that allowable write-ins will count toward the satisfaction of the minimum expectation or safe harbor standard (i.e., count towards the percentage threshold). Issuers will be working over the coming months to continue to add ECPs to their networks.

We recommend that issuers be afforded an opportunity to upload an updated ECP template later this summer to account for any additions since the submission window. We also note that issuers should be permitted to update networks following the submission window of QHP applications, since networks are dynamic and may broaden.

We note that the requirements related to ECPs were recently announced as part of the January third Partnership Guidance– the percentage threshold ECP "*safe harbor*" and a requirement to offer contracts to one ECP in each ECP category per county (where available). In previous discussions with issuers and AHIP, CCIIO indicated its intent to learn more about ECPs and examine potential requirements while encouraging issuers to continue working to add ECPs to their networks. Issuers have been working diligently to do just that. Major questions remain. CMS has not released the total universe of ECPs available and how this threshold would be calculated, as CMS has not yet issued an updated ECP list. Publication of this list is critical. Our members have been analyzing the list of 340B providers from HRSA's website to help assist in identifying ECPs, but there are problems with this information, as it contains duplicate National Provider Identifier (NPI) numbers and omits Federally Qualified Health Centers. Health plans should also have the opportunity to indicate that ECPs on the CMS list were unable to be located, as many health plans have indicated that they have been unable to contact several of the ECPs included in the HRSA database, which we understand is the basis of the CMS list.

Questions also remain as to whether plans will be required to report by facility or provider. The reporting level will greatly impact health plan's ability to meet the safe harbor threshold.

We also note that some of the ECP types identified have not historically been provider types with whom health plans have contracted for services (for example - black lung clinics). And some of the community clinics or providers have indicated they operate on a cash only basis, and not on an electronic claims or billing process. A number of the ECPs contacted have not previously had the experience of contracting with health plans, and will need to develop the administrative support necessary to negotiate and sign contracts, as well as develop the appropriate claims and billing infrastructure. And health plans will need to develop the credentialing, contracting and payment processes to apply to the ECPs, which have not previously been identified. We note these administrative challenges not as a complaint, but as a reality that will impact health plan's ability to meet the threshold standards by April 30, and therefore setting the threshold standards at this late date make them nearly impossible to meet.

For all of these reasons, we strongly urge CMS to eliminate these new requirements – the 20% Safe Harbor Standard, the 10% minimum expectation standard, and the ECP contract per county standard. Our plans remain committed to meeting all access standards, including those for ECPs and will continue working to ensure availability of these providers for vulnerable individuals.

We further recommend that the issuer application and template of ECPs permit issuers to indicate those ECPs that are currently network providers, and those that have been offered a contract for the application timeframe, with an updated list submitted later as the network develops.

We also suggest that the ECP certification needs to be modified for stand-alone dental plans. Dental plans do not traditionally work with the list of ECP facilities that medical plans do, and dental providers are not always available at all ECPs (for example at Ryan White treatment centers, etc.). We recommend that CMS and the FFE consider requiring only an "access plan" and a narrative of the actions taken by the stand-alone dental plans to identify and solicit dentists at ECP facilities to participate.

Section 2. Accreditation

For open enrollment in 2013 the Exchange will display selected CAHPS survey results from an issuer's accredited commercial product lines when these results are available. However, the Letter also notes that "If applicable CAHPS® data are not available through existing accreditation, the Exchange website will display a neutral statement such as "No data available.""

We are concerned that the reference to "no data available" may be misleading and not accurately represent the possible reasons a health plan may not have available data. A health plan may not be scored on HEDIS/CAHPS measures and therefore not have any survey data to provide. Alternately, an existing plan may not have had sufficient survey responses or sample size to produce CAHPS data. Finally, plans coming through the Exchange Add-on Survey do not submit HEDIS/CAHPS data and would therefore not be able to display survey results.

We are concerned over the lack of distinction between a QHP issuer who has either scheduled, or planned to schedule a review of its QHP policies and procedures with a recognized accrediting entity (and is thus in compliance with the standard published in 45 CFR 155.1045(b)) and a QHP issuer who currently does not have accreditation and has not scheduled, or planned to schedule a review of its QHP policies and procedures with a recognized accrediting entity (and are thus out of compliance with the standard published in 45 CFR 155.1045(b)).

We strongly recommend the Exchange website differentiate between these types of issuers by either:

- Displaying the accreditation status of a QHP issuer in accordance with the 155.1045(b) standard ("Accredited by NCQA", "Scheduled/Plan to be Scheduled for Review by NCQA", "Accredited by URAC", "Scheduled/Plan to be Scheduled for Review by URAC" "Accredited by NCQA and URAC" or "Not yet accredited"); or
- Displaying the accreditation status of a QHP issuer by phase of accreditation process ("Accredited by NCQA", "Accredited by URAC", "Accredited by NCQA and URAC", "Accreditation in Process" or "Not yet accredited").

Section 3. Review of Rates

We appreciate the clear deference to states' authority and oversight over rates, and that "CMS does not plan to duplicate reviews that a state is already conducting as a matter of state law, and will take into consideration reviews conducted on behalf of a state under the Effective Rate Review program as described in the Final Market Rules. CMS anticipates integrating state and other CMS rate reviews into its QHP certification processes, provided that states provide information to CMS consistent with federal standards and agreed-upon timelines."

We recommend a clear statement that CMS will accept rate determinations made by states with Effective Rate Review programs. We are concerned that the phrase "*CMS will take into consideration*" states' rate reviews could indicate that CMS intends to overrule the states' authority. We thus recommend the word "*accept*" replace the words "take *into consideration*" in that section.

We also ask for clarification regarding the steps CMS will take if the state is unable to provide the information to CMS in the timeframes specified, and the impact on issuers.

Section 4. Benefit Design Review

i. Non-discrimination

We are concerned regarding the lack of clarity around the "outlier analysis" CMS proposes, and how far that analysis extends. Specifically, CMS notes it will review information contained in the "explanations" and "exclusions" sections of the plans and benefits template with the objective of identifying discriminatory practices or wording. As part of this review, CMS expects to flag any language that it believes indicates a reduction in the generosity of a benefit *in some manner* for subsets of individuals that is not based on clinically indicated, reasonable medical management practices.

We are very concerned that under this proposed approach, issuers could be "caught in the middle" if a state has approved an issuer's contract language and CMS subsequently recommends language counter to that which has been approved by the state. Further, we are concerned that some plan designs, such as tiered networks, or prescription drug benefit designs with specialty drug tiers, could be inappropriately flagged for further CMS review. Extending the review beyond the cost-sharing provisions to the explanations, exclusions, and benefit templates may inhibit innovative benefit designs intending to better serve consumers, not discriminate against them.

Consistent with CMS' approach to defer to state authority where possible, we recommend that CMS defer to state approval of language in contract forms and exclusions. We believe that any recommended changes by CMS should be pursued in limited circumstances and that CMS discuss such changes with the state prior to requesting an issuer to revise its language. We believe such an approach is important to ensure that standards are applied consistently and to minimize burden.

We would also appreciate recognition by CMS on the issue of non-discrimination in services and the provision of EHBs and preventive services in cases of gender identity (where regardless of the gender one identifies with, the biological gender typically guides the coding of a medical procedure being billed).

ii. Supporting Informed Consumer Choice

We are concerned that the triggers for review outlined in this section are too narrow and arbitrary and may have the effect of restricting the range of options available for. This is particularly true with regard to deductibles, since a consumer may see a large difference between a $200 and $300 deductible – eliminating a $50 step up may eliminate a meaningful choice.

Section 5. Cost-Sharing Reduction Plan Variations and Advance Payment Estimates

We note that the last sentence of that section does not express its meaning clearly, and ask that it be clarified. It states: "*Finalized advance payment amounts will be identified for Exchanges to include enrollment information transferred to QHPs.*"

Chapter 2: Qualified Health Plan Certification Process in FFEs, including State Partnership Exchanges

We note a key concern on the speed to market of the reviews, and the potential for delays between the coordination and transfer of information between CMS and states and issuers. We recommend that CMS accept attestations from both states and issuers. For example, the QHP applications require a significant amount of data submissions to CCIIO that the states have already collected and reviewed. Thus we strongly recommend that CMS accept the attestations from the states as a means to expedite what will be a significant undertaking in any environment, but which in this short window will be a huge undertaking.

Section 1. QHP Application and Certification Process in Non-Partnership FFEs

The window for filing QHP Applications and all required templates through HIOS is too narrow. States have not yet all finalized their rating standards, and the Unified Rate Review Template has not yet been finalized. Yet the window to submit the QHP Application with all the required templates opens in only 2 weeks. We are very concerned that the April 1st to April 30th window for submitting the applications is inadequate for the volume of activity that must occur. For the first year, at such a frenetic pace, we fear the timeframe is too narrow, and provides no room for potential technical issues, HIOS systems issues, issuers' technical upload issues, etc.

This is the only opportunity that issuers will have to submit their applications or be "locked out" of the 2014 Exchange market in the FFE/Partnership states. For these reasons, we strongly recommend that for this first year, CMS should extend that window the end of May 2013 in order to ensure that issuers seeking to pull together all the required information in all the states they operate in can have the necessary time to complete and submit all the templates and filings.

We are also very concerned with the tight timelines for QHP certification, and the limited time for issuer review and response. For example, in June issuers will only be provided a 5-day window to review deficiencies and revise their applications for resubmission to HIOS. If issuer rework is required that may involve re-filing benefit plans and/or premium rates with the states as well, five business days is too short a time to complied those all. If CMS remains committed to that timeframe, we must ask that the window for state filings be held open to resubmit to them after first filing to HIOS. We urge CMS to provide plans additional time to review deficiencies to ensure that resubmissions are as robust as possible. In August, issuers will face another 5-day

window to identify and submit data corrections during the "plan preview" period. We note that the August 5-day window includes a weekend, so we ask that it be revised to 5 business days. Further, the September 5-day weekend includes a holiday weekend; we ask that this window also be revised to provide for 5 business days. We are aware of the tight timeline from April submission through certification, but request additional time for issuers to make these important data submissions and corrections.

We strongly recommend that CMS ensures that the technical help desk will be operational for extended hours during these narrow review and update windows. We appreciate the recent announcment that the help desk will be open to 8 p.m. Eastern Time beginning on April 1st.

And we ask that CMS provide issuers additional time to review and validate the accuracy of data that consumers will be using to compare plan options during the open enrollment period. In particular, if CMS still intends to provide for a "consumer browsing experience" in September, prior to open enrollment, issuers will need to review and validate that information, and be given the opportunity to request corrections before the October 1 go-live date.

Section 2. QHP Certification Process in a Plan Management State Partnership Exchange

We appreciate the clarification of the State Partnership Exchange timeframes and the latitude provided for states to manage the process.

Section 3. QHP Agreement

We recommend that CMS publish a model agreement for public comment prior to its use.

Section 6. Certification of CO-OPs for all Exchanges

We recognize that CO-OPs must meet the terms of the CO-OP Program, federal standards for Exchanges, and any state-specific Exchange standards, and agree with that fair treatment. We ask the CO-OPs be treated in a consistent fashion with other QHP applicants. Thus, we recommend that either CO-OPs be required to submit all the application templates, or that existing issuers in good standing be afforded the same treatment as CO-OPs – as noted by the following statement in the Letter : "*CMS does not expect to collect information beyond the QHP Application from CO-OP issuers in order to complete the deeming process in FFEs, including State Partnership Exchanges*."

Section 7. OPM Multi-State Plans participating in All Exchanges

We are concerned with the reporting requirements for the Multi-State Plan Program released in the OPM final rule allowing for comparison among plans and oversight activities that include

plans reporting on their HEDIS metrics and CAHPS surveys, independent of the source of plan accreditation. This is problematic, as URAC does not require HEDIS metrics as part of its accreditation. We recommend that OPM align future guidance with that set forth by HHS for reporting requirements in the Exchanges, and that OPM not impose additional reporting requirements in 2014. AHIP is providing this same recommendation to OPM.

Chapter 3: QHP Performance and Oversight

Section 2. QHP Issuer Compliance and Oversight

We are concerned with any requirements that issuers provide attestation of meeting certain QHP requirements when final regulations have not been issued for all standards related to Exchanges. For example, attestations cannot reasonably be required if the standards have not yet been finalized through future guidance or rulemaking (e.g. quality standards, transparency in coverage, or meaningful access).

CMS indicates its intent to use a risk-based approach to monitoring compliance, focusing first on issuers that show signs of potential performance issues or non-compliance. We agree that risk-based surveillance is a more effective way of identifying potential market issues, or in this case Exchange issues. We also note that risk-based surveillance can also be an indicator of lack of clear guidance or consistency of information to regulated entities. Thus, we suggest that the approach also be used to monitor the oversight of the 25 or 26 FFE, in order to assure consistency in Exchange operational standards and guidance given to issuers, as issuers will be dealing with a number of different CMS *"Federal Account Managers.*"

We also recommend that CMS eliminate a "Compliance Plan" requirement in the Letter. Instead, CMS should rely on issuer compliance, state compliance oversight and enforcement, and the aforementioned risk-based oversight approach that CMS contemplates. We recommend this to assure consistency in the QHP applications submitted. We are concerned that the language in the Letter sets forth a conflicting message – at one point indicating a Compliance Plan is not required for certification, and then at another indicating that CMS will consider the Compliance Plan in determining whether to certify a plan on an Exchange (implying a preference).

We recommend attestations be taken when the QHP agreement is signed later this year.

Section 3. QHP Marketing

The Letter notes that CMS recommends that all marketing materials distributed to enrollees and potential enrollees include a disclaimer and Health Insurance Marketplace logo. We strongly recommend that this remain a best practice, but not a requirement. We also suggest that issuers be permitted to include a contact number for Exchange enrollment and eligibility questions on

materials and on ID cards for Exchange programs. In states where a QHP must be offered both on and off Exchanges this would create an additional administrative cost; it would require issuers to maintain two separate marketing materials for the same plan, one on the Exchange and one off the Exchange.

We also suggest that on page 28 of the letter CMS replace "*Qualified Health Plan*" with "*Qualified Health Plan Issuer*", so that it would read "*we recommend that all marketing materials distributed to enrollees and to potential enrollees contain the following disclaimer: "[insert plan's legal or marketing name" is a Qualified Health Plan Issuer in the [Health Insurance Marketplace]."* We suggest this for administrative simplification purposes, and so that the same disclaimer would appear on each of the issuer's Exchange QHPs.

Further, the last paragraph notes that "*QHP issuers must ensure that all marketing products and materials meet the meaningful access standards described in Chapter 6, Section 6... .*" We are concerned that this may be an overly broad standard to apply, since some "materials" may be website information, or premium invoices that should not be required to be produced in numerous translations. It is more concerning because such requirements have not yet been defined. In the preamble to the final rule CMS indicated that access standards for individuals with limited English proficiency and individuals with disabilities would be established in future rulemaking, and in this letter, in Chapter 6, CMS suggests it will issue "guidance" in the future, and that "*QHP issuers will be held to whatever standards will ultimately apply as a result of that guidance."*

We strongly recommend that CMS should provide for the opportunity for public comment in developing these requirements through a formal process.

We further recommend that issuers be subject to a "good faith effort" standard until final rules have been published and that any standards or requirements issued be applied prospectively.

Chapter 4: Stand-alone Dental Plans

We note that this chapter provides a helpful summary of the operational requirements for and treatment of Stand-alone Dental Plans in Exchanges. Table 4.1 is especially helpful in that regard.

iii. Displaying Stand-alone Dental Plan Rates

The last sentence in the first paragraph in this section is unclear, and should be reworded to reflect the language of the final rule. Specifically, the following statement "CMS *will also calculate the advance payment of the premium tax credit for stand-alone dental plans using the pediatric dental EHB premium allocation."* should be adjusted to indicate that APTC would only

be applied to stand-alone dental plans when there was an APTC amount left over after paying the medical QHP APTC.

Chapter 5: Consumer Enrollment and Premium Payment

Section 2. Payment of Premiums

i. Initial Premium Payments

For termination notices due to non-payment of initial premium, CMS has noted it believes that providing an explanation of any associated liability for medical claims that may have been incurred would be a best practice for QHP issuers. We recommend that this remain a best practice and not a requirement, allowing issuers to implement policies that are consistent with current policies.

ii. Initial Premium Payment Cut-off Dates and Cancellations

We support the ability for an issuer to cancel a policy and not effectuate enrollment if full and processed payment is not received by this cut-off date. However, we expect that many enrollees in the Exchange will rely on "paper" payment methods (e.g., paper check, money order) that will require the issuer's web portal to create a bill as opposed to transacting an immediate payment for an EFT or credit card payment. Paper payment methods will take longer for issuers to receive and process and some additional flexibility will be needed.

The last paragraph in this section refers to when a qualified individual makes a QHP selection, but later selects a new QHP before the coverage effective date, which would result in the initial QHP selection being cancelled by the Exchange as part of the transmission of updated enrollment information to QHP issuers. We request that in such circumstances, the Exchange notify the QHP issuer if the qualified individual has selected another QHP.

ii. APTCs and Premium Payments from Qualified Individuals and Enrollees

We recommend that the FFE should not submit the advanced payment tax credit (APTC) and cost sharing reduction (CSR) payments to the QHP issuer until receipt of an enrollment confirmation from the QHP issuer has been received.

We would also like confirmation that the report required of QHP issuers on the status of qualified individual and enrollee premium payments would only apply to those receiving the APTCs and/or CSRs. We would also like clarification on whether the reporting is only for initial payment or ongoing, and the format of that report.

Section 4. Transmission of Enrollment Information between the FFE and QHPs

We recommend that further guidance be provided on whether the transmission of enrollment information will be provided as of a specific date and time, or if it will be an aggregated stacking of the individual's changes. The Companion Guide has not clarified this and it is needed to assist issuers with implementation. We also ask that CMS refer to the version of the Transaction ASC X12 834 throughout the document to alleviate any ambiguity. We are also looking for for further guidance on the contingency process for ensuring that an enrollment file in non-electronic data interface (EDI) format be transmitted to issuers. We ask CMS to provide the timing and guideline(s) for this contingency process.

i. Enrollment Transaction Acknowledgement Files (ASC X12 999)

We recommend that CMS outline all the appropriate level of acknowledgments. The proposed guidance makes it appear that the only appropriate acknowledgment to confirm receipt of a file is a 999. We recommend the following:

- TA1 identifying file receipt or rejection.
- 999 identifying Functional Group level acceptance, rejections or partials.
- 999 identifying Transaction Set acceptance, rejections or partials.

We also recommend that additional guidance be written to only have one policy and its policy members be submitted within one ST to SE transaction set. Should an error occur in a policy, this allows only the affected policy to reject while allowing the non-erroneous policies on the file to continue to process. This practice alleviates enrollment processing latency for any non-erroneous policies on the file. Otherwise, the entire file will reject causing all policies to be rejected. We recommend that the 999 only include Syntax level 1-2 editing. The 999 is not robust enough to allow for additional levels of editing. We recommend that guidance be published on what other type of error reporting transactions will be exchanged. This is a critical step in the process to ensure that daily discrepancies are identified and rectified so as not to cause latency with enrollment processing.

iii. Enrollment Confirmation Transaction

We recommend outlining or defining the enrollment activities that would require issuers to use the ASC X12 834 as a confirmation transaction to ensure uniformity across issuers.

Section 5. Termination of coverage and Cancellation Options

We have previously noted the concerns with the issue of dependents "aging off" a plan – and who "owns" that responsibility for termination. Many states have the requirement that dependents that are continuously handicapped and dependent upon the enrollee for support must

be covered under the policy past the limiting age, as long as that disabling handicap continues. The problem with the Exchange being responsible for transmitting those terminations is that the health plan and not the Exchange may have learned that a child is handicapped and therefore allowed (required by state laws) to remain on the plan beyond age 26. Therefore, we recommend that issuers should be responsible for notifying the Exchange of any cases where the individual should be continued past the limiting age for reasons of continuous disability and continued dependency on the parent, and that such coverage be extended in accordance with state laws.

We also recommend that the reference in that paragraph in parentheses to fraudulent activity be expanded to include "or material misrepresentation".

Section 6. Grace Periods for Non-Payment of Premiums

We appreciate the additional information related to grace periods. We continue to be concerned about the lack of detailed information available to allow our members to operationalize the three month grace period within their systems. For example, we have identified conflicts between the statutorily required 90-day grace period for enrollees receiving APTCs with state prompt pay laws. In many states, issuers would be in violation of the state's prompt pay law if they exercise the option to pend claims following the first month of the grace period. While some prompt pay laws would not apply during the three month grace period due to the definition of a "clean claim," this is not universal. A state's definition of "clean claim" can help plans justify why a claim was paid or not. Some states include a specific exception for premium payment or eligibility; however, most states include language that could be interpreted as being such that "clean claim" means a claim with no defect or impropriety, or needs to include "all information necessary for an insurer to pay." This would mean issuers would be liable for all claim payments during the grace period putting them at financial risk, when they are required to return the APTC for months two and three of the grace period.

We ask that you work with states to address these potential conflicts.

In the letter, CMS notes the three month grace period applies to those enrollees who have already paid their share of one month's premium in full, and then the enrollee subsequently misses a premium payment. We recommend that each health plan have the ability to define "paid in full" as today certain issuers do currently accept "short" payments (i.e., the member's payment is short one month after having paid in full in past months). For example, a range of 95-99% of the premium amount owed is a viable proxy for full premium payment (to account for any data entry errors). Given the high cost of administrating operational processes surrounding the grace period this flexibility is important and will help maintain high levels of customer service for enrollees.

Another issue involved with the grace period that, along with the conflict with state prompt pay laws, is the difficulty in pending pharmacy claims during a grace period because they are point-

of-sale, real time transactions. We would like to discuss options for handling these claims during the grace period.

Section 7. Notice Requirements

We understand the importance of providing notice to both enrollees and providers regarding the required notices of premium non-payment.

We recommend that issuers have the flexibility to incorporate notice of non-payment of premiums into existing operational processes and offer detailed comments on the enrollee and provider notice below

i. Notice of premium Non-payment – to enrollees

We appreciate the approach whereby CMS provides general information on the content of the notice without providing a specific notice template. This flexibility is important given the notices must be built into plan systems by January 1, 2014. With respect to notices to enrollees, CMS should provide additional clarity and guidance on the requirements for such notice, such as an example of language for plans to build upon. Additionally, the Exchange should be responsible for notifying the issuer of the enrollee's preferred language, to assist in sending these notices. CMS guidance should fully afford the ability for issuers to use electronic notices.

In the notice to enrollees, issuers are required to include an "explanation about the three-month grace period, including applicable dates." We recommend referencing payment by the due date, and not referencing the three-month grace period, which could encourage members to wait until the last month to pay their premium. Potential member confusions will increase the operational burden and expense on the carriers. Since the 90 day grace period rules will be included in enrollee's plan documents, we would prefer telling members that they must pay by that invoice's due date, or risk termination.

ii. Notice of Pending Claims to Providers

We recognize that the Exchange final rule included the requirement that health plans notify providers "of the possibility" for denied claims when an enrollee is in the second and third month of the grace period. Thus, we recommend health plans have the flexibility to incorporate this requirement into their current "notice of claim" standards that are a part of many states unfair claim settlement practices acts, or prompt pay acts. As an alternative, we recommend that all provider notices are permitted to be electronic and should leverage existing electronic standards such as the 271 eligibility transaction and the 835 electronic remittance advice transactions. And we request clarification that issuers will have the flexibility to identify "potentially affected providers" as those who issue claims during the grace period.

The notice must include the names of all individuals affected under the policy and possibly under the care of this provider. The word possibility in the rule and the letter creates unnecessary ambiguity and thus we recommend CMS focus its approach only on notifications only to providers when claims were submitted.

Section 8. Enrollment Reconciliation

We recommend that the Annual Letter only addresses the requirement for a monthly enrollment process at a high level and that details regarding the specific process for enrollment reconciliation process are removed. The reconciliation process is still under development in consultation with issuers and technical experts and the final process is expected to be different from that which is detailed here. We have raised significant concerns with the bi-directional process as outlined in the Letter and have provided an alternative process that relies on a uni-directional process that preserves the Exchange as the source of truth and mitigates the operational burden of identifying discrepancies and making changes.

We look forward to continuing to work with CMS to develop this process.

Section 10. Agents and Brokers

Issuers ensure that actions taken on their behalf by agents and brokers acting on their behalf comply with applicable federal and state requirements. We are concerned, however, with the extension of this requirement to the web-brokers who hold an agreement with the Exchange, and who operate the agent and broker portal for the Exchange. We recommend that the Exchange/FFE establish the requirements and assure that any web-brokers authorized to access the Exchange should comply with the standards of the Exchange as well as applicable federal and state requirements.

Chapter 6: Consumer Support

Section 1. Call Center and Website

We view this section as focused on the FFE/State Partnership Exchange (SPE) Call Center(s) and Website. We are concerned that is not fully clear that only the FFE/SPE Call Center(s) are being discussed. Thus we ask for clarification that this section speaks to the FFE/SPE Call Center(s) and is not additional or new regulations being placed on QHP call centers and websites.

We also strongly recommend that on the FFE/SPE Website(s) where appropriate, there should be links to QHP issuers' websites wherever possible, to provide customer assistance for additional explanations, access to consumer tools and information.

Section 4. Complaints Tracking and Resolution

The Call Center Complaint Tracking process needs to distinguish between ***complaints*** and ***inquiries*** (requests for information or assistance), and keep separate counts and listing of those for improved performance in later audits. And it is important to distinguish between complaints regarding issuer performance and complaints regarding Exchange performance. Specifically, this process for identifying complaints should distinguish complaints or inquiries reflecting Exchange performance that result from an enrollee's understanding of the plan design (e.g., application of a deductible), benefits, or cost sharing subsidies that reflect the consumer's shopping experience at the Exchange, not the plan's performance.

We recommend complaints related to the Exchange, which could include complaints about navigators, in-person assisters, application counselors, the Exchange Call Center hold or wait times, or dropped calls, or website, account or sign-on issues - be separately tracked and identified as Exchange complaints, and not complaints related to issuers' performance or coverage.

If the call is a complaint about issuer performance, or consumers' dissatisfaction with the level of payment made for services, or application of deductible, or related to denial of services and appeals, it should be "hot transferred" to the issuer and tracked as a complaint.

If the inquiry to the Exchange is to understand the status of a claim, cost-sharing or deductible information, how to file a claim, or how to access a health plan website, etc., those inquiries should be "hot transferred" to the issuer, and tracked as inquiries.

Section 6. Meaningful Access

There is considerable evidence that language barriers adversely affect healthcare quality, patient safety, and timeliness in access to care that can contribute to health disparities for patients with limited English proficiency. Key stakeholders agree that better data on patient language preferences (written and spoken) are needed to effectively address language-related barriers to timely, high quality healthcare.

Issuers have a long-standing commitment in addressing health disparities to improve the quality of care for all diverse populations, including individuals with limited English proficiency. AHIP supports a requirement that QHP issuers provide applications, forms and notices to enrollees in "*plain language"* and in a manner that is accessible and timely to individuals with disabilities and individuals with limited English proficiency. However, we do not yet have a regulatory definition of "*plain language*" - what was referred to previously in the final Exchange rule in

March 2012. We look forward to the proposed rulemaking that will address that and other important elements of meaningful access.

The Letter mentions that, "*for limited-English proficient speakers, providing meaningful access includes providing oral interpretation, written translation and taglines in non-English languages indicating the availability of language services*." Issuers can facilitate the use of oral interpretation via telephonic interpreter services, either in-house or external, for notices and applications. However, we seek additional guidance on the required thresholds for providing languages services. We encourage CMS to be consistent with other program requirements set forth under ACA, such as the Summary of Benefits and Coverage (SBC) and/or appeals and grievances requirements under PHS Act section 2719.

In addition, we strongly recommend a phase-in approach for inclusion of taglines in languages other than English to allow issuers to assess and determine what services and resources are needed by individuals with limited-English proficiency that actively seek assistance through the health plan's call center, website or other form of communications.

We agree with the recommendations described in the Letter that issuers inform individuals of the availability of services, how consumers can access these services, and that language services will be provided at no cost to them.

Finally, we request a general clarification of which marketing products and materials specifically are subject to these and other marketing requirements (e.g., materials that provide general information but not specific to a QHP).

Appendix B: Process Flow For QHP Certification

<u>The Non-Partnership FFE</u>

The 5th "Process Box" provides just 4 days for all issuers to resubmit any requested revised data into HIOS, from June 18 to June 21. This is too narrow a window if there are any technical glitches or process challenges at any time during that narrow window. We thus strongly recommend that the window be open for a week, from the 18th to the 25th.

Appendix C: Additional Guidance on EHB RX Coverage, AV and Cost Sharing

<u>EHB Prescription Drug Coverage</u>

iii. Prescription Drug Exceptions Process

We recommend that the exception process should mirror existing state requirements without imposing a new CMS exceptions process standard. Not all states require a third party Independent Review Entity for a second level review of pharmacy exceptions. As a result, issuers would be required to default to the approach suggested (which is mirrors the Part D exceptions process) which is not consistent with the typical commercial plan exceptions process governed under state regulation. In addition, the suggested exceptions process outlines clinical criteria for approval which interferes with the Pharmacy and Therapeutic Committee process (which is composed of pharmacists and physicians who develop and approve clinically sound coverage policy for the coverage of both formulary and non-formulary drugs).

Actuarial Value (AV) Calculator

As is outlined in the applicable regulation, this Letter indicates that AV calculation methods for evaluating incompatible plan designs must be certified by a member of the American Academy of Actuaries, and an actuarial certification must be submitted. We recommend that HHS release a uniform actuarial certification form for this purpose. With initial releases of the regulations, the certification was illustrated as a process rather than a signed form. We believe that reducing the process to a form will facilitate the plan design review and approval for both HHS and states conducting their own QHP and/or AV reviews.

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AHIP remains committed to successful Exchange implementation, and would be pleased to discuss these comments with you in detail with you at your earliest convenience. You can contact me at cgallaher@ahip.org or at 202-778-8487.Thank you.

Sincerely,

Candy Gallaher, Senior Vice President
AHIP State Policy