April 21, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9949-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Exchange and Insurance Market Standards for 2015 and Beyond

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments on the Exchange and Insurance Market Standards for 2015 and Beyond.

§ 155.120 Non-Interference with Federal Law and Non-Discrimination Standards

We understand the concern of HHS that organizations receiving federal funds to serve a defined population that also serve as certified application counselors (CAC) may want to limit the populations the entity serves as a CAC. We are concerned, however, that the proposed exemption is both too broad and too narrow and sets a bad precedent.

Any entity that receives federal funding is independently subject to existing civil rights laws such as Title VI of the Civil Rights Act, Title IX, the Rehabilitation Act, and § 1557 of the ACA, regardless of whether it serves as a CAC. Since these laws do not provide an exemption to an entity for its broad scope of activities, why would it be allowed to discriminate when providing a more limited scope of services? Yet, as written, the proposed regulation could allow a recipient of federal funds to turn away an individual who normally would be a client/participant in the entity's activities on a discriminatory basis if the nondiscrimination provision does not directly apply. It also creates confusion between the application of existing federal civil rights laws which generally attach to the entire activities of an entity once federal funds are received, and the

proposed regulation which would allow an exemption for part of the entity's activities.

We recognize that a Ryan White program that serves as a CAC may seek to limit its CAC activities to Ryan White participants. But within that client base, the entity must still be prohibited from discriminating against those clients. Thus the nondiscrimination provision should apply *within* the eligible population while allowing the entity to exclude serving certain individuals based on other factors (e.g. ineligibility for Ryan White services). In other words, the exclusion of certain individuals from receiving the entity's CAC services is based solely on eligibility for the program/activity the entity receives federal funds for and not because of discrimination. We recommend that HHS clarify the limits of the exemption and only provide an allowance to limit CAC services to certain populations as long as the entity does not discriminate within the eligible population.

RECOMMENDATION: Add at the end of § 155.120(c)(2):

> If the organization limits its provision of certified application counselor services pursuant to this exception, it must comply with paragraph (c)(1) of this section within the defined population it serves.

§ 155.206 Civil Money Penalties for Violations of Applicable Exchange Standards by Consumer Assistance Entities in Federally-Facilitated Exchanges

We commend HHS for clearly delineating the circumstances in which CMS may assess civil monetary penalties against consumer assistance entities. While we anticipate that most consumer assistance entities will comply with all applicable requirements and standards, civil monetary penalties are an important compliance and enforcement tool to ensure that entities and individuals charged with assisting consumers to access insurance affordability programs do not harm or mislead those consumers and that there are consequences for bad actors. We fully support that civil monetary penalties will be assessed only in those situations where a violation of the applicable requirements is knowing and willful. Consumer entities may unwillingly or negligently fail to comply with certain requirements, but re-training or clearer guidance will be more effective to correct those situations than civil monetary penalties. We support the approach of giving consumer assistance entities that have willfully or knowingly failed to comply with the rules 30 days to take corrective action before assessing monetary penalties. These limitations will help encourage a broader group of organizations with varying degrees of experience to participate as consumer assistance entities and, more importantly, ensure that civil monetary penalties are a punishment reserved for the most egregious offences. We also support that the proposed regulation provides HHS the flexibility to negotiate a corrective action plan with a consumer assistance entity in lieu of assessing a penalty. This flexibility will help to ensure that consumer assistance entities can continue their important work of assisting consumers, especially in circumstances where a violation is limited or easily correctable.

In the preamble (at page 15823), HHS asked for input on whether it should provide for an expedited process for assessing civil monetary penalties. We do not believe that an expedited process is necessary, as the regulation as written already provides sufficient mechanisms to prevent and stop abusive practices by consumer assistance entities. We do not believe an expedited process is necessary as there are other more direct, effective avenues for consumers to obtain an immediate corrective action for a particular harm caused by a consumer assistance entity (*i.e*., improper enrollment or plan choice) that will not be necessarily resolved even with an expedited process for civil monetary penalties. We are also concerned that an expedited process will create a chilling effect that could prevent consumer assistance entities from carrying out their important work and discourage small, local organizations from pursuing opportunities to become consumer assistance entities.

HHS also requested input (at page 15184) on whether it should give the HHS OIG concurrent authority with CMS to enforce the civil monetary penalty provisions. While we encourage HHS to draw upon OIG's expertise in investigating waste, fraud, and abuse in order to determine where civil monetary penalties are appropriate, we believe concurrent authority is redundant and diffuses accountability for enforcement.

HHS additionally requested input (at page 15185) on whether it should create an aggregate cap on the amount of penalties that may be assessed. We would support application of an aggregate cap.

Finally, HHS also asked for input (at page 15826) on whether it should apply a specific limitations period to these provisions. We agree that a limitations period is appropriate, and suggest a period of five years.

We are concerned that the grounds for assessing a penalty, set out in proposed § 155.206(c), are stated quite broadly. Consumer assistance entities are potentially liable for any knowing and willful "failure to comply with the Federally-facilitated Exchange requirements and standards applicable to" that Entity. *Id.* Without knowing exactly which requirements and standards could subject them to liability, the efforts of consumer assistance entities may be chilled. We appreciate the examples of violations provided in the preamble and suggest that HHS explicitly limit liability to instances where a consumer assistance entity has failed to comply with provisions of 42 U.S.C. §§ 18031, 300gg-93, or 45 C.F.R. §§ 155.205, 210, 215, 225, as applicable to that Entity and that there is an actual, material harm to a consumer that was directly created or caused by that entity. By expressly stating with which provisions consumer assistance entities must comply with to avoid penalties and that the actions must result in actual harm to a consumer, HHS can mitigate the potential chilling effect of these provisions and avoid unwarranted complaints or investigations.

RECOMMENDATION: We recommend amending § 155.206(c) as follows:

> HHS may assess CMPs against a consumer assistance entity if, based on the outcome of the investigative process outlined in paragraphs (d) through (i) of this

section, HHS has reasonably determined that the consumer assistance entity has failed to comply with the Federally-facilitated Exchange requirements and standards ***set forth at 42 U.S.C. §§ 18031, 300gg-93 and 45 C.F.R. §§ 155.205, 210, 215, 225, as*** applicable to the consumer assistance entity, **and that the entity's action led to a material harm to a consumer(s) who was directly assisted by that entity**, *unless* a CMP has been assessed for the same conduct under 45 CFR 155.285.

§ 155.210 Navigator Program Standards

NOTE: We are concerned that this and the other sections of the proposed "preemption" rule could be read as a statement by HHS that the doctrine of .285.) who was directly assisted bly to the ACA. State laws are preempted when it is impossible to comply with both the federal and state law at the same time, as the proposed amendments recognize. State laws are also preempted, however, where the state law constitutes an obstacle to the implementation of the goals of the federal law, even if there is no express conflict. By not expressly stating that "obstacle" preemption applies in connection with the ACA, these amendments could invite ACA opponents to argue that HHS intends that obstacle preemption not apply, and thus that the language "prevent the application of" in the ACA be construed to encompass only the "impossibility" theory of preemption. We recommend that HHS expressly acknowledge that xpressly acknowledge thataies to state laws regulating all types of consumer assisters.

We commend the addition of a non-exhaustive list of specific examples of state standards that HHS considers to prevent the application of title I of the Affordable Care Act. As of September 2013, at least 14 states in the Federally-facilitated Exchange and 2 states with Partnership Exchanges have enacted laws to regulate Navigators.[1] The National Health Law Program is counsel to the plaintiffs in *St. Louis Efforts for AIDS v. Huff*, the federal court case that obtained a preliminary injunction to stop the enforcement of such a law in Missouri. As a result of our work in this case and from talking to advocates in other states that have enacted similar laws, we know well the serious chilling effect that over-regulation of consumer assistance entities can have and the very real limitations that laws like the one at issue in *St. Louis Effort for AIDS* pose on consumers' access to complete and impartial information about their health coverage options. A recent study by researchers at George Washington University found that community health centers in states that had passed restrictive navigator laws were significantly less likely to engage in outreach and education or to enroll patients in new forms of coverage.[2] In addition to the examples currently listed in the proposed regulation at 155.210(c)(1)(iii), we suggest that HHS also include these examples: prohibiting Navigators from providing on-site assistance at local health centers (contained in guidance put forth by the Florida Department of Health); requiring Navigators to provide their credit rating (would be require by pending SB 362 in

[1] Partow Zomorrodian *et al., Navigating State Exchange Laws: An Overview of State Approaches to Navigator Regulation*, COMM. HEALTH FORUM, Fall-Winter 2013, at 18, 19.
[2] *Id.*

Kansas); requiring navigators to possess a GED or high school diploma (would be required by pending HB 1668 in Missouri); limiting the types of identification allowed; limiting hiring to registered voters; or requiring verification of citizenship or other similar factors.

We particularly commend the provision at § 155.210(c)(1)(iii)(A) that explains that any state law that requires Navigators to refer consumers to an insurance agent or broker would prevent the application of the ACA. We agree with HHS's statement in the preamble that, because insurance agents and brokers have no legal obligation to provide consumers with fair and impartial information, and it is currently common practice for them to steer consumers into specific plans, requiring Navigators to refer consumers to agents and brokers violates their duty to provide "fair, accurate and impartial" information, and to "provide information . . . about the full range" of coverage options (page 15827). By providing clarity to states that such requirements prevent the proper application of the ACA, HHS will help to ensure that states do not inadvertently reduce consumers' ability to make choices based on impartial and accurate information and instead help empower consumers to choose a plan based on their own needs, rather than the needs of an agent or broker. We strongly urge HHS to maintain this provision in the final rule.

We also commend the provisions of § 155.210 that provide additional consumer protections for those consumers who work with Navigators. We support prohibitions against charging consumers for Navigator services and soliciting consumers through robo-calls or unsolicited door-to-door contact. However, we urge HHS to limit prohibitions on unsolicited contacts to enrollment activities generally and provide exceptions where these activities may be solely used to provide targeted outreach and education to hard-to-reach populations, for example efforts to reach immigrant or homebound populations.

We are concerned, however, that § 155.210(c)(6) would immediately prohibit navigators from receiving compensation on a per-application, per-individual-assisted, or per-enrollment basis. Several states, such as California, have invested in and are already using such methods to compensate consumer assistors, including navigators. If HHS implements new compensation limits, it must at a minimum create an adequate transition period for states which have already invested in newly prohibited methods. At a minimum, HHS should not apply this provision to state-based Exchanges, in order to give states that are operating their own Exchanges the flexibility to design a compensation format that works for their state.

We also disagree with HHS's statement in the preamble (at 15830) that state rules that require Navigators to undergo a background check or fingerprinting generally do not prevent the application of the ACA. These additional requirements beyond HHS's requirements for Navigators place a substantial burden on potential Navigators and raise serious legal concerns. *Cf. St. Louis Effort for AIDS v. Huff*, No. 13-4246-CV-C-ODS, 2014 WL 273201 at 10 (preliminary injunction finding that educational requirements for Navigators beyond the federal minimum were preempted). This burden

creates an obstacle to achieving the ACA's purpose of providing access to coverage to uninsured individuals. HHS should clarify in the final rule that extra state background check and fingerprinting requirements are not consistent with the ACA.

155.215 Standards applicable to Navigators and Non-Navigator Assistance Personnel carrying out consumer assistance function under §§ 155.205(d) and (c) and 155.210 in a Federally-facilitated Exchange and to Non-Navigator Assistance Personnel funded through an Exchange Establishment Grant

We commend the application of § 155.210(c)(1)(iii) to non-Navigator consumer assisters. We disagree, however, with HHS's decision to exempt non-Navigator assisters from § 155.210(c)(1)(iii)(D), which will effectively allow states to limit non-Navigator consumer assistance to insurance agents and brokers.

Allowing states to require non-Navigator assisters to be licensed as insurance agents or brokers impairs consumers' interests. Insurance agents and brokers have financial interests in the outcome of consumers' plan selection—they will only be paid if the consumer selects one of the plans with which they contract. This financial motive will often—consciously or unconsciously—prevent agents and brokers from providing consumers with "information and services in a fair, accurate and impartial manner" as required by § 155.215(a)(2)(i). HHS states in the preamble (at 15827-28) that, because of the risk that insurance agents and brokers most likely will not provide fair and impartial information, HHS proposes to prohibit non-Navigator assisters from referring consumers to insurance agents and brokers. By the same token, we urge HHS to prohibit insurance agents or brokers from serving as consumer assisters all together. At a minimum, HHS should require that states cannot limit the consumer assistance available outside of the navigator program to be provided only by insurance agents and brokers as that is not consistent with the ACA and not in the best interest of consumers.

Similarly, allowing states to require assisters to hold errors and omissions insurance will improperly limit the scope of assistance available. Such insurance is only available to licensed professions in most states, is prohibitively expensive, and would effectively limit assistors to insurance agents or brokers.

RECOMMENDATION: We recommend amending § 155.215(f) as follows:

> *State or Exchange Standards*. All non-Navigator entities or individuals carrying out consumer assistance functions under § 155.205(d) and (e) must comply with the eligibility standard set forth under § 155.210(c)(1)(iii~~), except for § 155.210(c)(1)(iii)(D)~~.

§ 155.225 Certified application counselors

We are quite concerned that the proposed amendments would expressly allow states to regulate certified application counselors, even when a state has opted to have the federal government run the Exchange. These provisions run contrary to the language

of the current rule and its preamble. The current HHS rule says that "the Exchange" shall regulate certified application counselors. In FFE states, the Exchange is the federal government, so the federal government regulates certified application counselors. Because the language of the rule and its preamble is so clear, Texas—no friend of the ACA—exempted CACs from its rules restricting Navigators and other consumer assisters. Notably, Navigators are created by statute, but CACs have been created by HHS by regulation. There is no provision of the statute that even arguably authorizes the states to regulate CACs.

Moreover, allowing the states to regulate certified application counselors in FFE states is contrary to the court's holding in *St. Louis Effort for AIDS*, which states: "Any attempt by Missouri to regulate the conduct of those working on behalf of the FFE is preempted." The court's holding makes sense. As the court explains, the ACA gives the states a choice: they are free to choose either to set up their own Exchange or to have the federal government set one up. Once they opt for the latter they cannot then try to impose additional burdens on either the Exchange or those working on its behalf. This provision should be amended to remove the authority for state regulation of certified application counselors.

RECOMMENDATION: We recommend amending § 155.225(d)(8) as follows:

> § 155.225(d)(8) Meets any licensing, certification, or other standards prescribed by the State or Exchange, if applicable. . .

Along with this modification, we agree with the promulgation of a non-exhaustive list of specific examples of state standards that HHS considers to prevent the application of title I of the Affordable Care Act. For the same reasons described in detail above, we suggest that HHS also include these examples: prohibiting certified application counselors from providing on-site assistance at local health centers (contained in guidance put forth by the Florida Department of Health); requiring certified application counselors to provide their credit rating (would be require by pending SB 362 in Kansas); or requiring certified application counselors to possess a GED or high school diploma (would be required by pending HB 1668 in Missouri). We particularly support the provision at 155.225(d)(8)(i) that explains that any state law that requires certified application counselors to refer consumers to an insurance agent or broker would prevent the application of the ACA. By providing clarity to states that such requirements prevent the application of the ACA, HHS will help to ensure that states do not inappropriately limit the scope or quality of assistance available to consumers.

We also commend the provisions of 155.225 that provide additional consumer protections for those consumers who work with certified application counselors. We support prohibitions against charging consumers for navigator services and generally soliciting consumers through robo-calls or unsolicited door-to-door contact, though HHS should provide exceptions where these activities may be solely used to provide targeted outreach and education to hard-to-reach populations, for example efforts to reach immigrant or homebound populations .

For the reasons described in our comments to § 155.210(c)(6), we are concerned that 155.225(g)(3) would prohibit certified application counselors from receiving compensation on a per-application, per-individual-assisted, or per-enrollment basis. Finally, for the reasons described in our comments to § 155.115 above, to the extent that HHS permits any state regulation of certified application counselors in FFE states, HHS should include a preemption provision here, akin to § 155.210(c)(1)(iii)(D), regarding any state rules that require certified application counselors to be licensed as insurance agents and brokers, or to hold errors and omissions insurance. While HHS states in the preamble that this section will only allow agents and brokers who do not sell health insurance to serve as certified application counselors, we believe that additional regulatory language is needed to make HHS's intention clear, and to prohibit states from requiring all certified application counselors to be licensed insurance agents or brokers.

RECOMMENDATION: We recommend adding the following subsection to § 155.225(d)(8):

> § 155.215(d)(8)(vi) Requiring that a certified application counselor hold an agent or broker license or carry errors or omissions insurance.

§ 155.240 Payment of Premiums

We support the proposed amendment to § 155.240 to allow proration of the premium amount owed by consumers who are enrolled for a part of a month. The amendment is in the best interest of the consumer and ensures that consumers only pay for the benefit of coverage actually received. The amendment will also allow consumers to enroll for a partial month when newly enrolling in a QHP rather than requiring a gap in coverage and delay of enrollment at the 1st of the month due to affordability barriers.

We also support the formula described in the regulatory language – dividing the amount of the premium by the number of days of the month and multiplying the number of the days actually enrolled. This would be the simplest formula to use for proration and easily understandable to consumers making this formula preferable to other proration options. We recommend that if exchanges are given the flexibility to establish one or more standard processes for premium calculation for a prorated month, as described in the preamble at page 15834, that one of those processes to be used must be this simplest formula.

§ 155.260 Privacy and Security of Personally Identifiable Information

We support the proposed amendment to § 155.260 that specifies civil monetary penalties will be imposed for *knowing and willful* violations of § 1411(g) of the ACA and that penalties for violations of § 155.260 will be consistent with penalties imposed under § 155.285.

In addition, to ensure consistency between § 155.260 and the new §§ 155.210(e)(6) and 155.225(f) in this proposed rule, we recommend the use and retention of personally identifiable information (PII) with consumer consent be explicitly recognized and added at § 155.260. The proposed rule adds §§ 155.210(e)(6) and 155.225(f) which require navigators and assistors to obtain consent from a consumer prior to the consumer sharing PII with the navigators. If the consumer provides informed consent prior to sharing of their PII as required, it should follow that navigators are permitted to use and retain the consumers' PII to perform their duties as navigators and perform exchange functions. The navigators' ability to use PII with the consumer's consent as proposed at §§ 155.210(e)(6) and 155.225(f) should be explicitly included as a permissible use within § 155.260 as well. We suggest the following amendments to § 155.260 to include reference to consumer consent of the use of PII.

RECOMMENDATION: Amend § 155.260(b) as follows:

> Application to non-Exchange entities. Except for tax return information, which is governed by section 6103 of the Code, when collection, use**, retention,** or disclosure is not otherwise required by law **or authorized by a consumer**, an Exchange must require the same or more stringent privacy and security standards (as §155.260(a)) as a condition of contract or agreement with individuals or entities, such as Navigators, agents, and brokers, that:
>
> (1) Gain access to personally identifiable information submitted to an Exchange; or
>
> (2) Collect, use**, retain,** or disclose personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing the functions outlined in the agreement with the Exchange.

Amend § 155.260(a)(4) as follows:

> For the purposes of implementing the principle described in paragraph (a)(3)(vii) of this section, the Exchange must establish and implement operational, technical, administrative and physical safeguards that are consistent with any applicable laws (including this section) to ensure—
>
> (i) The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed by the Exchange;
>
> (ii) Personally identifiable information is only used by or disclosed to those authorized **by the Exchange or the consumer** to receive**,** ~~or~~ view**, or retain** it;
> ……
> (vi) Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with **authorization of a consumer and** retention schedules;

§ 155.285 Bases and Process for Imposing Civil Money Penalties for Provision of False or Fraudulent Information to an Exchange or Improper Use or Disclosure of Information

We support HHS's use of a broad definition of "person" in § 155.285(a)(2) to determine who may be subject to CMP for violation of fraudulent use or improper disclosure. We recommend that HHS add to the factors listed at § 155.285(b)(2) used in determining the amount of CMP (at § 155.285(b)(2)(i)) to include consideration of whether the violation resulted in other legal consequences. Currently, this section does not capture situations where the disclosure resulted in other serious actions against the victim, such as deportation of an immigrant whose immigration status was improperly disclosed.

RECOMMENDATION: We recommend amending § 155.285(b)(2) as follows:

> The nature of the harm resulting from, or reasonably expected to result from, the violation including:
>
> > (i) Whether the violation resulted in financial harm;
> > (ii) Whether there was harm to an individual's reputation;
> > (iii) Whether the violation hindered or could have hindered an individual's ability to obtain health insurance coverage;
> > (v) The actual or potential impact of the provision of false or fraudulent information or of the improper use or disclosure of the information; ~~and~~
> > (vi) Whether any person received a more favorable eligibility determination for enrollment in a QHP or insurance affordability program, such as greater advance payment of the premium tax credits or cost-sharing reductions than he or she would be eligible for if the correct information had been provided~~.~~***; and***
> > ***(vii) Whether the violation resulted in other legal consequences for an individual.***

We suggest that HHS amend § 155.285(e) to explicitly allow individuals to request a hearing past the deadline if there is good cause. Right now, someone who fails to request a hearing timely, even if she has a good reason for missing the deadline, has no remedy.

RECOMMENDATION: We recommend amending § 155.285(e) as follows:

> Failure to request a hearing. If the person does not request a hearing within 60 calendar days of the date of issuance printed on the notice described in paragraph (d) of this section, ***or show good cause for not requesting a hearing within 60 days,*** HHS may impose the proposed civil money penalty.

In the preamble (at page 15835), HHS requested input on whether it should retain the discretion to impose CMPs under both sections § 155.285 and § 155.206 or limiting its

authority to only impose CMPs under section § 155.285. We recommend that HHS retain discretion to impose CMPs under both sections. We can imagine privacy violations that will also violate consumer assistance standards and requirements and encourage HHS, in those instances, to levy penalties under both provisions. Allowing penalties under both provisions will give navigators and assistors in the FFE an extra incentive to maintain the privacy of those they assist.

§ 155.410 Initial and Annual Open Enrollment Periods

We appreciate the request for input on the shift in notice provided to consumers about redeterminations prior to the beginning of open enrollment. We recommend that the notices be sent no later than October 31. Many individuals may need to gather documentation for redetermination (such as proof of income) or may want to consult with an enrollment assister prior to redetermination. The option of allowing notices to be sent up until the first day of open enrollment could hinder some individuals from getting the assistance they need, particularly given that this open enrollment period will encompass both Thanksgiving and the winter holidays. We thus recommend HHS adopt its first option and ensure that notices are sent no earlier than October 1 and no later than October 31.

We also recommend that notice be provided not only to existing enrollees of QHPs but also to:

1. Potential enrollees of QHP who submitted applications after the close of the open enrollment and were subsequently determined eligible for QHP but unable to enroll;
2. Individuals who had applied for a special enrollment period but were denied during the past year;
3. Individuals who had requested enrollment information from the exchange during the period between open enrollments; and
4. Individuals who were terminated from a QHP during the period between open enrollments.

§155.420 Special Enrollment Periods

§ 155.420(b)(2)(i)

We support the changes in the regulation allowing a later coverage date for individuals whose circumstances change due to a birth, adoption, or placement in foster care or for adoption. It is difficult to predict all the situations in which a family might find itself; however, allowing the choice of either the date of birth/adoption/placement or a later coverage effective date provides the consumer with the opportunity to decide what is best for the consumer's family. In all cases, the marketplace must provide the consumer with sufficient information to make an informed choice and should not lead a consumer to a particular choice for factors other than the family's preference.

§ 155.420(c)(2)

We support the clarification that people who know they will lose minimum essential coverage within 60 days have the ability to establish Marketplace coverage ahead of time and minimize or avoid gaps during the transition, and that this ability is not limited to just those people losing employer-sponsored coverage.

§§ 155.420(d)(1) and (e)

We strongly support rules that ensure that pregnant women can access the comprehensive coverage to which they are entitled. Thus, we appreciate the inclusion, in subparagraph (d)(1), that a woman who loses Medicaid pregnancy-related coverage is also eligible for an SEP. However, we urge HHS to include an additional provision to account for additional situations in which pregnant women will need an SEP, at least until states are fully implementing federal rules pertaining to pregnant women's coverage requiring comprehensive coverage under the ACA and Medicaid.

The Department of Treasury rules exclude pregnancy-related Medicaid coverage from the definition of minimum essential coverage (MEC), making pregnant women who are in the income range for both APTCs and pregnancy-related Medicaid coverage potentially eligible to enroll in a qualified health plan (QHP) with APTCs and pregnancy-related Medicaid coverage. The exclusion of pregnancy-related Medicaid coverage from MEC recognizes not only the time-limited nature of pregnancy-related Medicaid coverage but also the fact that some state Medicaid programs currently provide pregnant women with a lesser scope of services than non-pregnant adults. Indeed, a number of states have submitted SPAs indicating that they will provide pregnant women covered under the pregnancy-related category less than full Medicaid coverage. It is entirely possible that a pregnant woman will not know at the time of application precisely which services are covered since not all states clearly delineate which services are excluded. (Of course, all states and the FFM should provide pregnant women adequate and timely notice about the differences in coverage between a QHP and Medicaid, including any differences in benefits, premiums, and cost-sharing). A pregnant woman who discovers, after enrolling in Medicaid, that the services she needs are only available through a QHP should not be penalized.

The current Treasury rules appropriately entitle women eligible for pregnancy-related Medicaid coverage and APTCs to: (1) use APTCs to purchase QHP coverage; (2) enroll in Medicaid; *or* (3) use APTCs to purchase QHP coverage and receive additional coverage by enrolling in Medicaid under the pregnancy-related category. To date, these options are not actually available to most pregnant women (due to confusion, misinformation, technology barriers, etc.).. HHS must ensure that states and the FFMs enable women to exercise these choices as they are entitled to do under the law. At the very least, until these legal entitlements become a reality, pregnant women should have an SEP to enroll in QHP coverage while receiving additional coverage under Medicaid's

pregnancy-related category or if they choose to voluntarily terminate their Medicaid coverage.

We accordingly strongly support providing an SEP at the loss of Medicaid pregnancy-related coverage. However, we urge HHS to also include an SEP when a woman voluntarily terminates Medicaid pregnancy-related coverage or when she needs an SEP to take up APTCs and enroll in QHP coverage, while maintaining additional coverage through Medicaid's pregnancy-related category, at least until states and the FFMs are fully implementing rules surrounding pregnant women's comprehensive coverage. Doing so ensures that pregnant women can access the comprehensive coverage to which they are entitled.

§ 155.420(d)(6)

We urge HHS to include an additional provision to ensure there is an SEP available to certain people who experience a change in life circumstances that makes them newly eligible for subsidies. Currently, the rules permit only people already enrolled in a QHP or those losing eligible employer-sponsored coverage (that previously barred them from getting subsidies) to qualify for an SEP due to becoming newly eligible for APTCs. However, between April 1 and November 15, 2014, when the 2015 open enrollment period begins, a substantial number of people who did not apply for Marketplace coverage on or before March 31, or who applied and did not enroll because they were denied subsidies and could not afford coverage, will experience changes in circumstances that affect their ability to obtain and afford health insurance. Without changes to the regulations, some of these people will be unable to enroll in coverage until November 15, 2014, and their earliest coverage effective date will be January 1, 2015.

RECOMMENDATION: Amend 45 CFR §155.420(d)(6) by inserting a new subsection (iii) and making the current (iii) subsection (iv). The new subsection would read as follows:

> (iii) A qualified individual or his or her dependent has a change in income or tax household composition or tax household size resulting in a determination that he or she is newly eligible for advance payments of the premium tax credit; or

Changing the policy as we recommend would allow people in the following situations, including death of a spouse, to qualify for SEPs:

- *People who would have been eligible for Medicaid but live in states that did not make the Medicaid expansion and who become newly eligible during the year for premium tax credits because of an increase in income or a change in household composition or size.* Because of their low incomes, many people in the Medicaid coverage gap will likely remain uninsured in 2014. However, some people may experience an increase in income or a change in household size during the year that would make them eligible for premium tax credits. Under current rules, they would

not qualify for an SEP unless they: had applied for coverage and been denied Medicaid, received an exemption from the shared responsibility payment based on being in the Medicaid coverage gap, and subsequently lost the exemption because of their increased income.

Guidance that HHS issued in June 2013 states that loss of a hardship exemption, including the exemption for people in the Medicaid coverage gap, triggers an SEP. It is our understanding, however, that many groups providing enrollment assistance did not have the capacity to provide help to people who clearly were ineligible for subsidies, and many people may not have even sought help if they knew they were ineligible. If people who were in the coverage gap get a job or otherwise have a change in income or household size during 2014 that makes them eligible for premium tax credits, they are unable to qualify for an SEP unless they had obtained a hardship exemption certificate from the Marketplace.

Even then, only people whose income goes above 138 percent of the poverty line would actually lose the exemption. Those whose income ends up between 100 and 138 percent of the poverty line would still qualify for an exemption and could not qualify for an SEP, even though they are now eligible for premium tax credits.

- *People who divorce during the year.* Under current rules, divorce itself is *not* a triggering event for an SEP, and some of the changes that divorce can bring — such as a substantial decrease in income and a change in tax filing status, and hence a change in APTC eligibility — only trigger the current subsidy-related SEP for people *currently enrolled* in a QHP. Some people in this situation may get an SEP if they were enrolled in a spouse's employer plan (because of the loss of coverage) or they move after the divorce to an area offering different QHPs. But if other such circumstances do not make them eligible for an SEP, they will have to wait, uninsured, until the next open enrollment period.

- *People who have access to employer-sponsored coverage but do not enroll in it because, while it may meet the ACA's technical definition of affordability, it is not affordable in practical terms.* These are people who have an offer of employer-based coverage but have not enrolled in the coverage, because they find it too expensive. If such a person loses his or her job and thus loses access to the job-based plan, the individual (and his or her family) could become eligible for Marketplace subsidies because they are no longer subject to the firewall. But the individual may not be able to access a Marketplace plan outside of open enrollment without the change we are recommending, because he or she would not qualify for an SEP related to loss of employer coverage since the individual had not enrolled in the employer plan.

- *Survivors of domestic abuse that occurs after May 31, 2014.* Guidance issued by the IRS on March 26 allows married survivors of domestic abuse to qualify for premium tax credits in 2014 even though they file their taxes separately from their spouses. The guidance on complex cases gives people in this situation until May 31

to apply and enroll in coverage. Someone who experiences domestic abuse after May 31 would not qualify for an SEP even if they separated from their spouse and knew they would be filing their taxes separately unless they meet another SEP requirement (or are Native American since they can enroll once per month). Many survivors of domestic violence may not meet another SEP requirement yet should be able to enroll prior to the next open enrollment so that access to health insurance is not used as leverage for the survivor to have to stay in the relationship.

§ 155.430 Termination of Coverage

We support the addition of the specific requirement, as discussed in the preamble at page 15839, that Exchanges must ensure that the insurer of a consumer whose coverage is terminated retroactively refund or credit premiums or co-payments paid by the consumer to the insurer for the period of coverage that was terminated. Unfortunately, rescission and termination of coverage by insurers of enrollees were common practices prior to the ACA. Consumers who were not made whole were left with little recourse to recoup amounts owed to them by the insurer.
We also support allowing Exchanges to establish operational procedures for QHP issuers for implementing terminations, cancellations, and reinstatements, as discussed in the preamble on page 15839. In fact, we recommend that HHS require, not solely permit, Exchanges to establish operational procedures for issuers in these circumstances. All insurers participating in the Exchange should be required to comply with similar procedures on terminations, cancellations and reinstatements so that there is a consistent process. It will also be helpful to insurers who are operating across service areas to have consistency of operational procedures. At a minimum, HHS should require Exchanges to provide best practices/model procedures for issuers to implement terminations, cancellations and reinstatements. Simplifying the procedures among QHP issuers will be in the consumers' interest and avoid consumer confusion, especially in situations where members of the household may be in different QHP plans.

§ 155.530 Dismissals.

The amendment to § 155.530(a)(1) allows for the withdrawal of appeals by telephone. If HHS finalizes a telephonic withdrawal option, we strongly urge HHS to maintain the requirement to provide a written confirmation to the appellant documenting the telephonic interaction. We also support HHS' requirements that the appeals entity be capable of accepting telephonic withdrawals and record in full the appellant's statement and telephonic signature made under penalty of perjury.

Subpart G—Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions

Required Contribution Percentage

Although the ACA sets 8% of income as the threshold for affordable coverage in 2014, it also directs the Secretary to adjust that number in future years. HHS' proposed

methodology is to multiply the threshold by a ratio based on dividing premium increases by income increases.

While we understand the statutory and perhaps practical necessity to adjust the affordability threshold, we believe the proposed ratio is problematic. Setting aside the data points used for the calculation, the ratio is problematic because the smaller the income in a given year, the larger the upward adjustment of the ratio – meaning that, holding premium rate increase constant, an individual would need to spend a *higher* amount out of pocket before reaching the affordability threshold the *less* income she earns. We recommend the calculation be adjusted in a way that corrects this general flaw. For example, HHS could adjust the formula as follows: the quotient of (x) one plus the rate of premium growth between the preceding calendar year and 2013, carried out to ten significant digits, over (y) one plus **the difference between** the rate of **premium** growth between the preceding calendar year and 2013, carried out to ten significant digits, **and the rate of income growth between the preceding calendar year and 2013, carried out to ten significant digits**. This formula can be summarized as:

$$\frac{1 + (\%\ \text{premium increase})}{1 + (\%\ \text{premium increase} - \%\ \text{income increase})} \times (\text{current contribution } \%)$$

Using the above formula, for any given premium increase rate: as income increases, the premium threshold also increases, and as income decreases, so too does the premium threshold. In all cases, we believe HHS should use an approach that minimizes volatility in the formula, and results in slow gradual change as opposed to large annual fluctuations.

We also recommend that HHS reconsider its use of GDP as a measure for income growth. HHS should consider (1) whether GDP is a good proxy for household income; (2) whether GDP sufficiently accounts for factors such as increased inflation, housing costs, etc., (3) whether GDP overstates the growth rate of lower income populations while understating the growth rates in higher income populations; (4) whether GDP adequately accounts for the lower proportional disposable income available to a low income single-earner household as compared to one with two high earning individuals. We are not convinced that a broad GDP average well-represents the income challenges of lower income households.

If the premium/income increase ratio is properly designed, we do support the application of negative *income* changes to the ratio. In a year where income decreases, it should be feasible for individuals to have a decrease in the affordability threshold. However, we do not believe a similar adjustment should be made for negative *premium* changes, because the purchasing power of a consumer is based on their disposable income, regardless of the average cost of a premium. Therefore, we would constrain the premium factor to a positive number, and recommend using a value of zero in the place of any negative premium growth.

§ 155.625 Options for Conducting Eligibility Determinations for Exemptions

The current regulations require states to adopt shared responsibility payment (SRP) eligibility decisions from HHS, with differing requirements before and after October 15. The newly proposed regulations would retain this process until November 15 (instead of October 15), but would eliminate the ability of states to adopt HHS decisions after November 15. States would be expected to carry out the SRP eligibility determinations themselves. We agree with HHS that it makes most sense for a single entity to conduct SRP eligibility determinations. Clearly, this is the long-term objective for Marketplaces. However, we know that both state-based Exchange as well as FFM states are currently experiencing delays in processing applications from open enrollment and still need to create proper procedures for processing applications for special enrollment. States also are devoting resources to preparing for the next open enrollment period, addressing critical IT fixes and eliminating enrollment barriers consumers experienced during the first open enrollment period. As a result, we are concerned that states will not have the resources to carry out this function by November 2014. We believe that HHS should provide states with more time to build capacity or at least make provision for states to request an extension to the November 2014 start date.

We also believe that regardless of when states take on this responsibility, HHS must provide clear guidance and ensure states are conducting the determinations appropriately. First, HHS must provide states with clear standards to implement, so that consumers are not harmed by state discretion misapplied to exemptions which are mandatory. For example, if HHS policy would require that all Medicaid enrollees are eligible for an exemption, including those with coverage that does not meet the minimal essential coverage standard (such as pregnancy or medically needy coverage), states should not be able to grant such exemptions on a merely discretionary basis. Second, we believe that consumers, Exchanges, and HHS' public relations are all best served by uniform implementation across states of a policy that has federal tax consequences.

§ 155.1400 Quality rating system

HHS asked for comments for future guidance on the display of quality ratings of QHPs offered in an Exchange for consumers and employers.

NHeLP applauds HHS for its proposal requiring Exchanges to prominently display the quality rating information assigned to each QHP on its Web site. The star rating system, as utilized for Medicare Advantage plans, provides consumers with an accessible and easy to understand means to consider and compare QHPs. However, consumers, health advocates, and members of the public should have full access to the methodologies and validated data used to calculate the ratings. We are encouraged that HHS expressed its commitment to provide in its ratings display the opportunity to " drill[] down to the results for individual quality measures if consumers should choose to access more detail of the data underlying the synthesized global quality rating." Consumers will benefit by having ready access to quality ratings, along with the ability to further research and consider the underlying bases for those ratings.

The ratings should also include an explanation of the process employed to calculate the ratings – perhaps using a hover box with a link for consumers to access more detailed explanations, methodologies and the validated data upon which the ratings are based. CMS should take measures to ensure that the available data is not outdated so consumers are basing selections on the most recent performance of the QHP.

Concerns over deceptive QHP marketing

HHS asked for comments on QHPs using quality ratings in marketing and the potential for deceptive marketing practices. We share concerns that QHPs may portray their quality ratings in advertisements and marketing in a deceptive manner. This concern must be addressed by the Exchanges and HHS through reviews of QHP marketing materials as part of its annual and ongoing compliances reviews as provided under 45 C.F.R. 155.1010 and related regulations. Exchanges and HHS must accept ultimate responsibility for the marketing materials consumers receive, and this requires an active system for reviewing plan materials and serious sanctions, including civil monetary penalties and decertification, for plans that violate the rules.

In addition to a system of monitoring and sanctions, HHS should require QHPs to include disclosure in all marketing materials that allow consumers to access, either via the HHS/Exchange website, or through printed materials, full information on the ratings systems, processes and underlying data. Such a disclosure statement on marketing materials would not place an undue burden on QHPs – in fact they are commonplace on political advertising under federal and local campaign finance and election laws.

HHS should consider other ways of measuring quality and consumer satisfaction

Quality ratings and enrollee surveys provide important insights into the performance of QHPs. However, HHS should consider additional measures that complement these important oversight activities and provide consumers with additional information to select a QHP.

NHeLP strongly urges HHS to require Exchanges to report on QHP grievances and appeals so that consumers can make informed choices at the time of plan selection. HHS is required to conduct compliance reviews as provided under 45 C.F.R. § 155.1010 looking at, *inter alia*, compliance performance using information received from various sources, including states, which may include: complaint data, issuer self-reporting of problems, information related to customer service and satisfaction, health care quality and outcomes, QHP issuer operations, and network adequacy. In addition, CMS committed to tracking consumer complaints, as described in 2015 Letter to Issuers, at 47, available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuer-letter-2-4-2014.pdf.

For example, for several years New Jersey regulators have published an annual report examining the number of appeals filed against managed care companies operating in

the private market, pursuant to the New Jersey Health Quality Act.[3] The reports include data on the number of appeals filed by plan and provider type, the number of appeals forwarded to an independent utilization review organization (IURO) for preliminary review, as well as the incidences where the IURO overturned the plan. Consumers benefit from learning which plans have high complaint rates and higher rates of coverage denials that are subsequently overturned.

§ 155.1405 Enrollee satisfaction survey system

NHeLP commends HHS for introducing an enrollee satisfaction survey. Members of the public and consumer advocates should have the opportunity to review and analyze the validated data submitted to HHS that is used to compile the results of the survey for QHPs. We note also that satisfaction is not by itself a sufficient measure of quality, as it will not provide as complete a quality picture as a survey that also includes experience with care. We also encourage CMS to include questions that address satisfaction with interpretive services for individuals with LEP and questions about accessibility for individuals with disabilities. By including such questions and providing greater transparency, consumers will have the opportunity to assess the overall quality of a health plan before making a selection.

In addition, child only surveys and quality measures should apply not only to child only plans but to all plans that serve children.

§ 156.122 Prescription Drug Benefits

§ 156.122(a)

NHeLP supports HHS' clarifying that the prescription drug standard in § 156.122(a)(1) was not intended to discourage issuers from offering clinically appropriate drugs to enrollees, including combination drugs.

The fact that concerns have been raised about access to necessary medications due to overly restrictive formularies suggests that the underlying EHB standard should be strengthened. While we support a robust and consumer-friendly mechanism for obtaining necessary off-formulary medications, relying on a broad exceptions process will always be piecemeal and leave some people out. For this reason, we reiterate our comments that recommend strengthening the underlying prescription drug EHB standards in §§ 156.122 from the November 2012 NPRM on Standards Related to

[3] See the New Jersey reports at http://www.state.nj.us/dobi/division_insurance/managedcare/ihcapreports.htm.

Essential Health Benefits, Actuarial Value, and Accreditation. Our previous comments are available online, and we incorporate them here by reference.[4]

§ 156.122(c)

We commend HHS for requiring an exceptions process that allows an enrollee to request appropriate drugs that are not covered by the health plan. Many individuals, such as those with complex medical interactions or allergies, may be unable to safely use medications in a limited formulary. HHS asked for comments on what specific standards would be appropriate for defining the exceptions process required under 45 C.F.R. § 156.122(c). Foremost, we recommend that the timeframe for obtaining access to medication should be shortened to no more than 24 hours after a request is made, given the serious health consequences that gaps in treatment can cause, particularly in those with severe, disabling, or chronic conditions.

Additionally, we encourage HHS to establish clear standards with regard to how such requests are made and processed to ensure transparency and usability for all enrollees, including individuals with disabilities and LEP individuals. At a minimum, HHS should:

- Require plans to notify enrollees about the existence of an exceptions process and instructions on to make a request. Notifications should be written in clear, understandable language and be available in alternative and accessible formats;
- Require plans to accept exceptions requests in multiple formats, including at least telephone, mail, and secure web-based options;
- Set flexible standards about who is authorized to make a request for an exception (including patients, doctors, pharmacists, family members, caregivers, etc.);
- Establish clear parameters governing the criteria plans may use to evaluate and approve a request as medically necessary and how an individual might appeal the plan's decision;
- Potential consequences if the decision is not made within 24 hours.

In addition, HHS should monitor requests for medication exceptions, as well as the timelines of decisions and outcomes. Inordinately high rates of exceptions could indicate overly restrictive utilization management or drug formularies that are too limited to adequately meet enrollee's needs.
In future rulemaking, we urge HHS to consider making this exceptions process broader than the prescription drug coverage category. With the significant insurer flexibility proposed in this rule, it is especially important that there be a consistent, easy-to-use exceptions process for accessing all services recommended by an individual's treating provider but not covered by the health plan.

[4] Comments available at: http://www.healthlaw.org/publications/search-publications/Comments-9980#.

§ 156.130 Cost-Sharing Requirements

We realize that Congress has changed the underlying statute on the small group deductible limits since this NPRM was released and so offer no specific comments to the proposal.[5] Generally, we support the method of rounding down adjustments, which will greatly simplify calculations and reduce the potential cost sharing burden over time. We also note that research has clearly demonstrated that deductibles are blunt policy instruments that lead individuals to reduce both necessary and less necessary care in roughly equal proportions.[6] Furthermore, even when key preventive care services are exempted from the deductible, a number of studies have shown that a substantial percentage of enrollees (19-32%) remain unaware of the exception and report avoiding or reducing preventive care due to cost.[7]

§ 156.200 QHP Issuer Participation Standards

We support the amendments that require insurers to attest that they will comply with all operational requirements upon certification as well as when seeking certification as discussed in the preamble on page 15846. Compliance with federal and state law as well as any operational or sub-regulatory guidance should be required for any issuer participating in the Exchange as a minimum requirement for certification.

§ 156.800 Available Remedies; Scope

We support the proposed amendment to § 156.800 that would permit HHS to "consult and share information about QHP issuers with other Federal and State regulatory and enforcement entities" as discussed in the preamble on page 15847. We recommend however that this sharing of information of insurers by HHS with other regulatory and enforcement entities not be limited to information "necessary for HHS to determine whether an enforcement remedy under subpart 1 is appropriate" (page 15848). Regulatory agencies in the states may not be able to determine violations by insurers without HHS' sharing of its information of insurers, and state agencies should be provided the broadest scope of information HHS has collected on the performance and compliance of insurers within the FFM. This will allow for broader analysis and identify potential actions by insurers that may not yet rise to the level of a violation in need of enforcement.

More importantly, we recommend HHS make this information available to consumers in a manner that is easy to understand. In order to ensure consumers are able to make

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[5] PL 113-93 (HR 4302) § 213. Striking para (2) of ACA § 1302(c).
[6] Robert H. Brook et al., *The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate* (RAND Corporation) (2006), http://www.rand.org/pubs/research_briefs/RB9174.html.
[7] Mary E. Reed et al., *In Consumer-Directed Health Plans, A Majority of Patients Were Unaware of Free or Low-Cost Preventive Care*, 31 Health Affairs 2641 (2012); Jeffrey Kullgren et al., *Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans*, 170 Archive Internal Med. 1918 (2010).

informed choices about their enrollment, information about an insurer's practices within the service area and elsewhere, especially where violations occurred, would be helpful to consumers. Disclosure of this information across service areas to consumers would provide more transparency of issuers' practices and may also create incentives for insurers to reduce or prevent violations from occurring for fear of losing enrollees.

§ 156.1120 Quality rating system

See comments on § 155.1400 above.

§ 156.1125 Enrollee satisfaction survey system

See comments on § 155.1405 above.

§ 155.740 SHOP Employer and Employee Eligibility Appeals Requirements

We support the proposed amendment to allow telephone withdrawals of SHOP appeals similar to the proposed amendment for appeals in the individual market at § 155.530. We support the requirement that if an appeal is withdrawn by telephone, written confirmation to the appellant must be provided – either as part of a dismissal notice or a separate notice as necessary for due process. We recommend that the written confirmation of the dismissal also provide clear instructions on how to appeal this dismissal if the telephone withdrawal was not actually requested by the appellant.

Conclusion

Thank you for the opportunity to comment. If you have any questions, please contact Leonardo Cuello (cuello@healthlaw.org) at the National Health Law Program.

Sincerely,

/s/

Emily Spitzer
Executive Director