July 28, 2014

Submitted electronically via: www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9941–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: CMS–9941–P
Comments on NPRM "Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges," (July 1, 2014) and
CMS "Guidance on Annual Redeterminations for Coverage for 2015," (June 26, 2014)

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. NHeLP provides technical support to direct legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people.

Thank you for the opportunity to provide comments on CMS' proposed rule "Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges ("proposed rule"), and the CMS "Guidance on Annual Redeterminations for Coverage for 2015," June 26, 2014 ("June 26 Guidance").

We provide our comments below specifically in regards to the proposed 2015 renewal process, as outlined in the proposed rule and June 26 guidance. We recognize there may be limited time to be able to fully incorporate recommendations for the 2015 renewal process and have also provided suggested interim recommendations where possible. We urge CMS to continue to revise the renewal process for 2016 based on our recommendations below as well as lessons learned from the 2015 renewals. In particular, we hope that for 2016 renewals, CMS will have sufficient information on plan premiums as well as tax data to redetermine APTC amounts rather than rolling over 2015 APTC determinations into 2016. We also urge CMS to ensure the necessary rate information and IT functions are available prior to the 2016 renewals for the renewal process to be as seamless as originally envisioned; for example, being able to accurately redetermine APTCs knowing the 2nd lowest cost silver plan available to the consumer. Our comments below are thus targeted to the proposed rule as applied to 2015 renewals and redeterminations.

A. Redetermination of exchange enrollees whose income falls below 138% of the federal poverty level (FPL)

We are concerned that the proposed rule only describes renewal scenarios where the enrollee's updated income is unchanged or has increased rather than decreased below current exchange or APTC eligibility levels. Under existing eligibility rules, if an enrollee's income for 2015 is below 138% FPL, he may be eligible for Medicaid if he lives in one of the Medicaid expansion states. If he lives in a non-Medicaid expansion state, he will remain eligible for advanced premium tax credits (APTCs) if his 2015 income is between 100-138% FPL. However, neither the proposed rule nor the June 26 Guidance describe what the exchange must do for enrollees whose updated income may fall below 138% FPL or are no longer eligible for APTCs based on a decrease in income.

First, we recommend that the final rule clarify that the exchanges should redetermine the enrollee's APTC at the same level as 2014 if an enrollee whose income has decreased (according to 2013 tax data) is not eligible for Medicaid in his state. We also recommend that the exchange inform consumers in this situation of the current eligibility levels for APTCs and that if household income for next year falls below 100% FPL, the enrollee will no longer be eligible for APTCs. Since 2013 tax data is not dispositive as to an individual's 2015 expected income on which the APTC will be determined, we do not recommend withholding APTCs for those whose income is below APTC eligibility per 2013 tax data.

Second, we recommend that CMS require exchanges to assist with Medicaid and CHIP enrollment if an enrollee becomes newly eligible based on a decrease in income at renewal. If an individual has received APTCs in 2014 but a check of 2013 tax data indicates the individual may be eligible for Medicaid or CHIP, we recommend that the individual be automatically screened for Medicaid/CHIP eligibility (if the state has expanded Medicaid) and transferred to Medicaid if eligible. Because these coverage programs offer a broader scope of services with lower out of pocket expenses, Medicaid and CHIP will provide a more affordable coverage option than coverage in the exchange for eligible individuals. We recommend that CMS prohibit exchanges from placing

additional burdens on consumers who are eligible and must be enrolled in another insurance affordability program at annual renewal, such as requiring a new application. The exchange should provide the state Medicaid agency the enrollee's information, including the updated income, so that the Medicaid agency can seamlessly enroll him in Medicaid or CHIP. We also recommend CMS require the exchanges to assist with Medicaid enrollment – whether conducting a Medicaid assessment or transferring enrollee's eligibility information - within a specified timeline to ensure the individual's Medicaid coverage is effective on January 1, 2015. Where applicable, if an enrollee who is newly eligible for Medicaid, but does not pro-actively enroll in a Medicaid managed care plan, the exchanges should be permitted to allow an issuer to auto enroll an enrollee from his current qualified health plan (QHP) to a Medicaid managed care plan of the same issuer, if the issuer is also a participating provider in the Medicaid program.

Below we provide amendments to 45 C.F.R §155.335(h) that reflect the recommendations discussed above.

RECOMMENDATION: Amend § 155.335(h) as follows:

(h) *Redetermination and notification of eligibility.*

(1) After the 30-day period specified in paragraph (e) of this section has elapsed, the Exchange must—

. . .

(ii) Notify the enrollee in accordance with the requirements specified in §155.310(g); ~~and~~

(iii) If applicable, notify the enrollee's employer, in accordance with the requirements specified § 155.310(h)~~.~~**; and**

(iv) Implement changes resulting from a redetermination under this section, provided such efforts -

(A) Would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay,

(B) Comply with applicable requirements under §§ 155.260, 155.270, 155.315(i), and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information, or

(C) Would not result in loss of coverage for an enrollee.

. . .

(3) In the case of a redetermination by the Exchange that results in an enrollee being initially screened as eligible for Medicaid, CHIP, or BHP, the Exchange shall –

(i) Implement changes resulting from a redetermination under this section on the first day of the month following the date of the notice; or

(ii) Maintain the enrollee's existing eligibility determination without considering the updated information if the redetermination would result in a loss of coverage.

(4) In the case of a redetermination that initially results in an enrollee being ineligible for advance payments of the premium tax credit due to income below 138% FPL -

(i) the Exchange must maintain his or her eligibility for enrollment in a QHP without advance payments of the premium tax credit and cost-sharing reductions, in accordance with the effective dates described in § 155.430(d)(3).

(ii) the Exchange must notify the enrollee of the initial finding of ineligibility and provide the enrollee 30 days to submit additional, updated income information.

(iii) the Exchange may not terminate eligibility for APTC until eligibility is redetermined using the most current income information or an enrollee fails to respond to the notice of initial ineligibility within 30 days.

B. Coordination of annual redeterminations for "mixed coverage" families

We are concerned that without further guidance from CMS, annual redeterminations specifically for mixed coverage families will lead to duplication of efforts and consumer confusion. "Mixed coverage" families consist of certain family members who are enrolled in a QHP in the exchange (e.g., parents) and other members who are enrolled in Medicaid (e.g., children), which occurs due to differences in Medicaid and exchange income eligibility. Similar to the annual redetermination process in the exchange, most Medicaid enrollees must also undergo annual redetermination. But because Medicaid is open for enrollment year round, the timing of the annual redetermination for Medicaid members of the household may differ from the exchange's annual redetermination in the fall. Yet the same, updated annual income or household changes will be required in order to renew exchange or Medicaid eligibility.

As a result, we are concerned that mixed coverage families may be required to provide the exact same updated information, two separate times in a year – once to Medicaid and then to the exchange – for different members of the household. Fortunately, many states delayed Medicaid annual redeterminations for 2014, but will resume redeterminations in 2015. Thus, we recommend CMS provide guidance for 2016 and beyond to help streamline the annual eligibility redeterminations for mixed coverage families in order to avoid duplication of efforts and consumer confusion. For example, we suggest that CMS require both Medicaid and the exchanges to first check for updated income information for mixed coverage families from the other entity, and to redetermine eligibility based on that updated income, if provided within the past three months. We look forward to working with CMS and other stakeholders to develop specific recommendations that could help streamline the annual redetermination process for mixed coverage families.

C. Redetermination of APTCs for first time tax filers

Some current QHP enrollees who are currently receiving ATPCs may be filing a tax return for the first time in April 2015 for the 2014 tax year. Under existing eligibility rules, an

individual who had not previously filed taxes could qualify for an APTC if he agreed to file taxes for this first benefit year. As a result, some current enrollees will not have tax information to provide the exchange this year for redetermination of their APTC, even if they consented to electronic verification of their tax records. Based on the proposed rule, it is assumed these enrollees will receive an "Income Based Outreach Notice" (per the June 26 Guidance) since there will be no tax data available.

First, we recommend that exchanges be required to implement a clear process to ensure existing enrollees without tax history, are able to electronically provide alternate proof of income, including specifying which documents can be used to update their income information. Second, we recommend that CMS require that the Income Based Outreach notices from the exchanges clearly inform consumers on how to update their income and how to provide proof of alternate proof of income (e.g., what documents are accepted and how to upload documents). Finally, the Income Based Outreach notice should emphasize that an enrollee, who may not have prior tax data, may lose his APTC if he fails to update his income and provide alternate proof of current income.

RECOMMENDATION: Amend 155.335(l) to add at the end:

(l) *Limitation on redetermination*. . . .

If an enrollee has provided the Exchange authorization to obtain tax data, but the tax data is unavailable or cannot be verified by the Exchange, the Exchange must create a process for the enrollee to provide updated income information using other documentation and must redetermine eligibility based on alternate proof of income per paragraph (f).

D. Threshold for reporting changes at renewal

Based on the proposed rule, it is not clear whether exchanges "may establish a reasonable threshold for changes in income, such that an enrollee who experiences a change in income that is below the threshold is not required to report such change" at the time of annual renewal similar to redeterminations during the benefit year per §155.330(b)(2). Without this clarification, we are concerned that consumers will be required to update their annual income even if a difference of $1 exists between last year's and this year's household income.

We recommend that exchanges be required, rather than allowed, to establish a reasonable threshold for changes in income at annual renewal similar to redeterminations during the benefit year. We also recommend that the exchanges set the threshold no lower than a 5% increase or decrease in income between the current and prior year's income. In the event an enrollee does not report a significant change in income, but electronic verification of income by the exchange determines current income is not reasonably compatible for re-enrollment, the exchange shall resolve such inconsistencies per §155.315.

RECOMMENDATION – Amend 155.335(e) to add new (3) as follows:

(e) *Changes reported by enrollees.*

. . .

(**3) The Exchange shall establish a threshold of a 5% variance or more for changes in income, such that an enrollee who experiences a change in income that is below the threshold is not required to report such change**. **If any change in income reported is inconsistent with data obtained from other sources, the Exchange shall resolve the inconsistency per 155.315.**

E. Auto re-enrollment

1. Exchanges should be the responsible entity for auto enrollment

Under the proposed rule and 2015 guidance, if a current QHP enrollee does not affirmatively select a new plan during the renewal process, the current issuer will automatically enroll that enrollee in the same plan or another plan based on a prescribed order of priority.

However, we strongly recommend CMS require ***the exchanges, not the issuers***, be responsible for auto enrolling consumers who do not actively select a new plan. Requiring the exchange instead of the issuers to choose an alternate plan for auto enrollment will help ensure that the consumer's interest outweighs the issuer's interest, which is to retain a customer, regardless of whether another product or plan in the exchange, not just within the issuer's products, is better suited for that consumer.

If the exchange was responsible for auto enrollment, it could use an algorithm to identify a plan in the same metal level that is "most similar" based on objective criteria to determine in which QHP an enrollee should be auto enrolled. Some states already use such a method to auto enroll Medicaid applicants into a Medicaid managed care plan if no plan is selected, which could be used as a model for auto enrollment by the exchange at renewal.

If it is not feasible for the 2015 renewal process for the FFE instead of the issuers to be the responsible entity for auto enrollment, we recommend in the interim that CMS:

- Allow SBEs to auto enroll enrollees, rather than issuers, if the SBE is able to do so for the 2015 renewal process; and
- Clearly indicate in the final rule that CMS will require exchanges to be responsible for auto enrollment decision in future renewals.

2. Definition of "most similar"

Based on the proposed rule, if an enrollee does not pick a new plan, the issuer will auto enroll the individual in another plan from the issuer that is "most similar" to the existing plan. Yet it is unclear what criteria will be used by the issuer to determine whether another plan is "most similar" to the enrollee's existing plan. The proposed rule does not discuss whether the cost-sharing or premiums, benefits and services, networks, or actuarial value

of the old vs. new plan must be compared and deemed to be within an acceptable variance to allow the issuer to designate one plan as similar to another. We are concerned that without more specific and objective measurements as to what makes plans "most similar," consumers may be auto enrolled in a plan that may no longer meet their health care needs or budgetary limits simply because the issuer claims it so.

We recommend that CMS define "most similar" for purposes of auto enrollment. The definition should include specific criteria to compare and identify what amount of variance in the criteria will be acceptable when comparing two plans before the issuer is allowed to auto enroll an individual into a new plan. We recommend CMS require issuers to compare cost-sharing, networks, formularies, as well as premiums and benefits to determine whether a new plan is "most similar" to an old plan, rather than actuarial value. We also recommend that CMS require issuers to provide a side-by-side comparison of these factors in the notice to consumers, in a way that is easy for consumers to understand. The consumer will then have sufficient information to evaluate for himself whether the new plan is similar enough to meet his needs or whether he should pick a different plan.

3. Order of Priorities

The proposed rule provides an order of priorities that issuers must use when identifying a 2015 plan to auto enroll a consumer, if needed. While we urge CMS to require the exchanges not the issuers to choose plans for auto enrollment per our earlier recommendation, we provide comments on the order of priorities as described in the proposed rule.

First, we recommend CMS prohibit issuers from enrolling consumers in a plan outside the exchange if the consumer qualifies for APTCs. For consumers who are no longer eligible for APTCs, we recommend CMS require issuers to auto enroll the consumer into unsubsidized coverage offered in the exchange over unsubsidized coverage outside the exchange.

Where the same metal level plan is available for 2015, we agree the enrollee should be auto enrolled into the same metal level plan that is "most similar" per our recommendations above. However, we do not agree with allowing an issuer to auto enroll the individual in either a higher or lower metal level plan if an issuer no longer offers a QHP in the same metal level as the enrollee's existing plan. We are concerned that this order of priority places the issuer's interest ahead of a consumer's interest for several reasons.

First, one of key ways to ensure a consumer is auto enrolled in a plan that is "most similar" to his existing plan is to make sure the new plan is in the same metal level. The consumer's original choice of metal level is the best indicator of the consumer's priorities and budgetary limits. The consumer's choice of level should not be second guessed and ignored simply because the current issuer does not to offer a plan in the exchange in the same metal level for 2015.

Second, to be eligible for cost-sharing reductions (CSRs), individuals must enroll in a silver metal level plan offered in the exchange. Thus, a current enrollee of a silver metal level plan not only benefits from a lower premium as compared to a gold or platinum plan, but also from lower out of pocket costs. Although the difference in the amount of premiums between a silver and gold metal level plan may be minimal, the out of pocket costs may be significantly different between these two metal level plans due to the CSRs offered in connection with a silver metal level plan. Allowing an issuer to auto enroll an existing silver metal plan enrollee receiving CSRs to a lower or higher metal level plan could result in limited access to care if co-payments without the CSRs are cost-prohibitive.

Third, the proposed rule does not specify whether the consumer or the issuer will decide whether to auto enroll the individual into a higher or a lower level plan if the issuer no longer offers the same level plan. Assuming the issuer will decide whether to auto enroll the individual into a higher or lower plan, there is a 50% chance from the start that this decision will be the opposite of what the enrollee would choose for himself. Moreover, there are no criteria for the issuer to use to make this determination. At a minimum, the issuer should be required to consider the consumer's best interest over other factors when selecting a higher or lower tier for auto enrollment.

In terms of order of priority if the issuer no longer offers a plan in the same metal level, we recommend that CMS require the exchanges, not the issuers, to auto enroll an individual in the same metal level as the current plan for 2016 renewals and beyond. In the interim, for 2015 renewals, if a 2015 plan is not offered by an issuer in the same metal level of the enrollee's current plan, we recommend that CMS:

- Require the exchanges to inform consumers that they may be re enrolled in a plan that is not in the same metal level as their existing plan;
- Require issuers to clearly and conspicuously inform a consumer what tier the 2015 plan is and if it is the same, higher, or a lower metal level as the existing plan;
- Require the exchanges to remind consumers they can stay in the same metal level plan by selecting a new plan in the exchange, and the advantages of doing so;
- Require the notice to include specific information for current silver metal plan enrollees to emphasize the cost-sharing benefits that are only available if they remain in a silver metal plan; and
- Require that for the 2016 renewal and beyond, enrollees must be auto enrolled in the same metal level plan as their existing plan.

4. <u>Step by Step Process for Auto Enrollment</u>

Unfortunately, the proposed rule and June 26 Guidance lack sufficient details to completely understand the complete auto enrollment process as planned for 2015. We recommend CMS provide additional guidance that would include step by step instructions, specific deadlines, and identify which entity is responsible for ensuring each step in the process is correctly completed. Because there are so many moving parts in the renewal process, providing as much detail as possible regarding the process will help reduce consumer confusion and ensure accountability among all stakeholders.

For example, we identify the following questions about the auto enrollment process that would be helpful for the consumer to have further clarification on:

1) Is it the exchange's responsibility to ensure the issuer of the old plan is notified if an existing enrollee picks another issuer's plan?
2) If there is a problem with an enrollee's attempt to change plans from one issuer to another, should the consumer contact the exchange or the new and/or previous issuer?
3) Does the consumer have any responsibility to inform his existing plan that he will be disenrolling after he selects a new plan?
4) Confirmation of auto enrollment:
    a) Neither the proposed rule nor the draft issuer notices mention whether a consumer will receive confirmation of being auto enrolled if the consumer does not affirmatively act to change plans. Specifically, will an issuer be required to provide the enrollee a second notice confirming the auto enrollment after it occurs and prior to January 1, 2015?
        - We recommend CMS require issuers to provide written confirmation of an effectuated auto enrollment to an enrollee, which includes the plan ID, or any new member ID or member card?
        - We also recommend a draft of such a notice be released for public comment.
    b) Which entity – the exchange or the issuer - should an enrollee contact if he does not receive any confirmation from the issuer about being auto enrolled?
5) Which entity – the exchange or the issuer - has primary responsibility to ensure that all enrollees who did not select a new plan by December 15, 2014 are auto enrolled so that there is no gap in coverage? In the event a consumer should have been auto enrolled but was not due to error, what are his appeal rights and where should he file his appeal?

F. Draft Exchange notices

We strongly recommend that CMS release the three exchange notices – the Standard Notice, the Income-Based Outreach notice, and the Special Notice - for public comment and conduct consumer testing of these notices as soon as possible.

We recommend that every notice, not only the income-based outreach notice, include a clear, conspicuous message at the beginning that encourages enrollees to update their income information on-line so that their APTC and plan selection will be more accurate. We also recommend that the income-based outreach notice should reassure the consumer that the process to update one's income information may be as simple as providing authorization to check tax records.

We recommend CMS require the exchange and issuers to coordinate regarding the content and distribution of renewal notices to avoid conflicting information and consumer confusion. In particular, we urge CMS to delay finalizing the issuer notices until the process and exchange notices can be better coordinated. Consumers will be very confused if they receive renewal notices from issuers before notices from the exchanges explain the renewal process and provide an eligibility determination for 2015. This will trigger additional demand on limited consumer assistance resources just as enrollment is opening for the 2015 plan year. CMS should require exchanges to at least send the Standard Notice before any issuer notice is released.

In addition, we recommend CMS require exchanges to follow-up on the various notices by email or phone. Experience in Medicaid and CHIP has proven that consumers may need to be contacted multiple times to encourage them to take action. However, the exchange should filter out enrollees who have already acted before conducting any method of follow-up in order to avoid confusing enrollees.

1. Income-Based Outreach Notice

We recommend CMS clarify whether the Income-Based Outreach Notice will target enrollees with an increase or decrease in income of 50% or 50 percentage points of the FPL as there is confusion. We also recommend CMS clarify more explicitly if this notice will be sent to all enrollees with income above 350% FPL up to 500% FPL.

We recommend CMS require exchanges to develop income-based outreach notices for enrollees with income below 250% FPL based on the updated FPL thresholds (2014) who are not enrolled in a silver plan. There was considerable confusion among consumers as they shopped for coverage regarding eligibility for cost-sharing reductions. While the majority of consumers did choose silver plans, some opted for lower cost bronze plans or higher cost gold plans. In order for these consumers to get the greatest value from the financial assistance available to them, it is important to target them with additional outreach. Additionally, we recommend that as individuals contact the exchange to update their eligibility for 2015, the exchange should alert enrollees if they are newly eligible for CSRs due to a change in income and/or the updated FPL thresholds.

2. APTC eligibility redetermination notice

Under the proposed 2015 renewal process, exchanges will evaluate existing enrollees' eligibility for 2015 APTCs based on 2013 tax data from the IRS. However, this data may not result in the most accurate APTC determination. As a result, it will be critical for consumers to know what income was used to redetermine their 2015 APTC so that they can make sure to report updated income information for the most accurate APTC calculation. This is particularly important in 2015 since the first tax reconciliation process will not have occurred, giving consumers and administrators an opportunity to assess the level and source of discrepancies in income.

a. Income Information

We strongly recommend that CMS require the exchanges to provide consumers with details of the income on which their eligibility determination is based. All notices -- at application, renewal and when changes are reported -- should provide a clear summary of the income source and amount that will be used to determine their eligibility going forward.

As we have reiterated in previous communications with CMS, simple notice of a "bottom line" decision such as the amount of an advance payment of the premium tax credit is insufficient to provide an individual the information needed to decide whether the decision is correct, if it was based on correct information, or what information may be needed to appeal and overturn an improper decision.[1]

Notices **must**, in no uncertain terms, include the details on which the decision is made – including the income on which eligibility and the APTC is based – to comply with constitutional requirements. As stated in a federal case specifically addressing the inclusion of financial calculations:

> [The] public interest in assuring that health benefits will not be erroneously terminated or denied outweighs the State's competing fiscal and administrative concerns. ***Any inconvenience the State might suffer is out-balanced by the State's and the recipient's interest in providing health benefits to those who cannot otherwise afford them. The Court concludes that in order to understand the government's reason for the termination or denial, specific financial information must be included where applicable in order that errors may be corrected.***[2] (emphasis added)

One of the important pieces of the ACA is that there is "no wrong door" for an application for coverage. Every application must be treated as an application for Medicaid, APTCs, and CSRs.[3]

Thus, the FFM notice must contain a statement of the intended action (renewal and the APTC amount) and reasons for the action.[4] The notice must be "reasonably calculated" to afford the individual a meaningful opportunity to present her side of the story.[5] The notice must not presume that the individual already has a basis for understanding the

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[1] *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 14 (1978) ("The purpose of the notice under the Due Process Clause is to apprise the affected individual of, and permit adequate preparation for, an impending hearing."); *see also Mallette v. Arlington Cnty. Emps. Supplemental Ret. Sys. II*, 91 F.3d 630 (4th Cir. 1996).
[2] *Rodriguez v. Chen***,** 985 F. Supp. 1189, 1195 (D. Ariz. 1996).
[3] 45 C.F.R. § 155.302(d)(1); *see also id.* § 155.310.
[4] 42 C.F.R. §§ 431.206, .210.
[5] *Mallette v. Arlington Cnty. Emps. Supplemental Ret. Sys. II*, 91 F.3d 630, 640-41 (4th Cir. 1996).

redetermination.[6] It is not sufficient for an individual to challenge a decision and eventually obtain the information that should have been in the notice or call to receive additional information.[7] The base-line protections are especially important in the context of renewals when CMS is using income provided a year prior and when income information is checked against sources other than the individual and the individual cannot verify that correct information was used unless the information is contained in the notice.

Consumers need—and the law requires—a notice that contains the legally required information that will allow them to decide whether to accept the APTC determination or perhaps challenge the discontinuance of an APTC and whether to update their information in a timely and effective way. Thus a notice of redetermination that specifies the continuing (or discontinuing) APTC needs to include the basis for the decision, such as income, so that the person has the necessary information to decide whether the decision was improper and whether they should appeal that decision.

b. Other Information

We also recommend that exchange notices clearly indicate the due date enrollees must provide updated information if they want to have their APTC eligibility redetermined with updated income rather than using last year's income. It is not clear from the proposed rule or guidance whether a consumer, who may either pick a plan or be auto enrolled by December 15, 2014, would be able to get an updated APTC determination if he updates his income information after December 15, 2014 but before December 31, 2014. And if the consumer updates his income information after December 15, 2014, how and when will the issuer be notified of the change in APTC so that the consumer will be billed for the correct premium amount?

Based on our recommendations above, below is a checklist of the information that should be included in all exchange notices:

- The income on which the 2015 APTC amount is based;
- Clear, visual comparisons for ANY difference in co-payments, benefits or

[6] *Baker v. State*, 191 P.3d 1005, 1010 (Alaska 2008). *Cf. Kuehl v. Dep't of Soc. & Health Servs.*, 164 Wash. App. 1016 (2011)(holding the State did not violate Due Process by providing the individual multiple individualized documents and a notice that explained the State's determinations).

[7] *Allen v. Alaska Dep't of Health & Soc. Servs.*, 203 P.3d 1155, 1169 n. 68 (Alaska 2009) (citing *Vargas v. Trainor,* 508 F.2d 485, 489–90 (7th Cir.1974) (holding that benefit reduction and termination notices that did not provide reasons for the agency's action violated due process despite fact that recipients could call caseworkers to learn the reasons and stating that "[u]nder such a procedure only the aggressive receive their due process right to be advised of the reasons for the proposed action"); *Ortiz v. Eichler,* 616 F.Supp. 1046, 1062 (D.Del.1985) *aff'd,* 794 F.2d 889 (3d Cir.1986)); *see also Schroeder v. Hegstrom*, 590 F.Supp. 121, 128 (D.Ore. 1984), *Hill v. O'Bannon*, 554 F.Supp. 190, 197 (E.D.Pa. 1982) and *Vargas v. Trainor*, 508 F.2d 485.

networks (however minor the change may seem to the issuer) between the old and new plans;

- Clear instructions on how an enrollee can change plans, including to another issuer, if he chooses to do so;
- The unsubsidized and subsidized monthly premium amounts, if the enrollee remains in his current plan for 2015;
- Clear instructions on who the enrollee must notify if he wants to change from his existing plan or issuer;
- A link to the plan's Summary of Benefits and Coverage (SBC);
- A link to the plan's most current provider directory;
- A link to the plan's 2015 formulary;
- The consumer's appeal rights if a) not enrolled in the correct plan after changing plans, or b) if the amount of the tax credit for 2015 is not correct based on estimated income for 2015;
- Referral to the exchange call center and website as well as local assistors/navigators if the consumer has questions or wants help to choose another plan; and
- The 800# or website of the state insurance or managed care agencies that regulate insurance plans in the state.

G. Accessibility and Formatting of Notices

Along with ensuring the content of notices is meaningful to consumers, CMS should also ensure that notices are easy to read and understand, use plain language, and are accessible to all enrollees, including those who are limited English proficient or who have disabilities. Accessibility will improve the consumer's experience with the renewal process. Below are specific areas of concern and recommendations for drafting of the renewal notices.

1. Literacy Level

We are concerned that the literacy level of the notices may be too high for many low-literacy individuals to understand and complete. As an example, one study by the AMA Foundation found that among people with low health literacy skills, 86% could not understand the rights and responsibilities section of a Medicaid application.[8] These problems are more common in certain demographic groups such as the elderly, the poor, some minority groups, and recent immigrants. We strongly urge CMS to explicitly require all notices be written at a 6th grade or less reading level. If the original English notice is written at the appropriate literacy level, translations of notices will be also be effective and at the appropriate literacy level for LEP individuals. We also recommend

[8] Barry D. Weiss, *et. al., Health Literacy Educational Toolkit, 2nd edition* (AMA Medical Association Foundation and AMA Medical Association), at 12, *available at* http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf.

CMS require exchanges and issuers to work with literacy experts and to field test draft notices with low literacy populations to ensure the application is understandable. For example, the use of contractions should generally be avoided.

2. Compliance with non-discrimination protections

We strongly support the explicit requirement in the June 26 Bulletin that issuer notices must comply with 45 C.F.R. § 155.205(c) regarding non-discrimination and accessibility. We believe longstanding federal civil rights laws, such as Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973, as well as the ACA's nondiscrimination provision, section 1557, must apply to these notices. We recommend that CMS require that exchange and issuer notices comply with these federal requirements, as well as state laws that provide additional protections. We provide suggested amendments below to incorporate these recommendations.

In order to comply with these federal requirements, CMS must specifically ensure that all Limited English Proficient (LEP) individuals have meaningful access to the renewal process and receive needed in-language assistance. We appreciate the inclusion of taglines in Spanish in the draft issuer notices from the June 26 Bulletin, informing individuals how to get help in Spanish. Yet estimates are that 23% of Exchange applicants speak a language other than English at home, many of whom will not be Spanish-speakers. As a result, CMS must ensure the exchanges and issuers assist enrollees who speak other language with the renewal process. We strongly recommend that CMS require all renewal notices to include additional taglines, in at least 15 languages, informing other limited English proficient individuals how to access assistance.

RECOMMENDATION: Require taglines on all exchange and issuer notices by including the following on the front page or prominently and immediately behind the front page, in fifteen languages:

> *This notice is important. If you do not speak English and cannot understand this notice, we will get an interpreter to help you at no cost to you. Please call (XXX) XXX-XXXX.*

In addition, we recommend a large print tagline on notices so that individuals with visual impairments will understand how to obtain additional assistance.

RECOMMENDATION: Require a large print tagline on all exchange and issuer notices on the front page or prominently and immediately behind the front page, in large print:

> *This notice is important. If you need this notice in an alternate format, including large print, please call (XXX) XXX-XXX.*

We also recommend that CMS require issuers to provide translated versions of the notices in any language where 5% of the population or 500 of its enrolled population indicates it is their primary language. We strongly recommend HHS adopt policy setting

forth that the failure to translate documents when languages meet the percentage or numeric threshold is evidence of non-compliance with Title VI and Section 1557. Documents should be translated for each language group that makes up 5 percent or 500 persons, whichever is less, of the population of persons eligible to be served or likely to be affected by the program or recipient in a service area. This percentage and numeric threshold is in already employed in other federal agency policy guidance, with some programs and agencies employing even lower thresholds. A 5 percent and 500-numeric threshold better ensures that the intent and statutory requirements to provide linguistically appropriate services will be met. Further, the service areas relevant for the application of thresholds should be issuer-specific, encompassing the geographic area where persons *eligible to be served or likely to be directly or significantly affected* by the insurer are located. Moreover, because translation of complicated concepts into other languages is often difficult, we recommend that CMS require exchanges and issuers to conduct consumer testing of all translated versions of the notices with the intended audience, in addition to consumer testing of the English notice.

Finally, CMS must also require exchanges and issuers to provide renewal notices and other information to ensure access for people with disabilities, including use of large print, TTY helplines and Braille versions. Individuals who utilize TTD/TTY machines must have information provided on how to access that assistance. Further, it cannot be assumed that blind or low-vision persons have someone available to read notices to them, or that people with developmental disabilities or speech impairments cannot independently understand this information. Important best practices include making notices available in a range of alternative formats such as Braille, large font print and electronic discs, including information that is translated into other languages, and communicating directly with an individual with a disability (or his or her chosen representative) to ask for his or her preferred communication methods.

RECOMMENDATION – Amend § 155.335(c) by adding subsection (4) as follows:

(4) The Exchange shall ensure notices comply with § 155.230(b) and with any applicable State laws and regulations regarding accessibility and readability requirements of notices.

RECOMMENDATION – Amend § 156.1255 by adding subsection (e) as follows:

(4) A health insurance issuer shall ensure notices issued under this section comply with § 156.250 and with any applicable State laws and regulations regarding accessibility and readability requirements of health insurance issuer notices.

3. Formatting Requirements of Notices

If a notice is not easy to read or consumer friendly, a consumer is less likely to attempt to read, let alone understand the notice. An unread notice ultimately is an ineffective notice. To help increase the likelihood a consumer will read the renewal notices, we recommend CMS provide formatting guidelines, as suggested below, which exchanges and issuers should be required to follow when drafting renewal notices.

- Include more white space;
- Use clear headings;
- Write from a consumer's perspective, not the exchange or issuers' perspective;
    - This includes assuming no prior knowledge of a renewal process or health insurance industry practices;
    - Use of the "you" pronoun rather than "we" or "I";
    - Providing only the information that is most relevant to a consumer;
    - Anticipate likely questions or concerns that a consumer would have and address those concerns;
- Use a Q&A format for example, rather than long paragraphs;
- Avoid use of jargon or acronyms;
- Use plain English that is at or below a 6th grade reading level;
- Draw visual attention to key dates and deadlines;
- Use active rather than passive language;
- Provide as succinct an explanation of a process as possible; and
- Always provide contact information to someone who can answer a consumer's likely questions about the notice.

H. Alternative Renewal Procedures - §155.335(a)(2)(ii)

We recommend CMS require that any state that seeks to utilize an alternative renewal process comply with federal requirements in terms of consumer protections, accessibility of and content for all notices. We recommend, however, that states be given flexibility to further simplify the renewal process or make the notices more accessible and consumer-friendly. For example, family members enrolled in different plans should receive the same renewal information so that there is one clear process regardless of which plan a family member is enrolled in.

We recommend that any alternative procedure require the state based exchanges to review and approve issuer notices and that public comments and consumer testing be required for notices from both the exchanges and issuers. We also recommend CMS provide an explicit checklist of the information that must be included in alternative notices rather than simply indicating that the "information outlined earlier in this bulletin" be included. Below we provide suggestions for a checklist of information that an alternative renewal process be required to provide consumers to obtain approval:

- Clear instructions on how an enrollee can change plans, including to another

issuer, if he chooses to do so;
- The unsubsidized and subsidized monthly premium amounts, if the enrollee remains in his current plan for 2015;
- Clear instructions on who the enrollee must notify if he wants to change from his existing plan or issuer;
- A link to the plan's most current provider directory;
- A link to the plan's 2015 formulary;
- The consumer's appeal rights if a) not enrolled in the correct plan after changing plans, or b) if the amount of the tax credit for 2015 is not correct based on estimated income for 2015; and
- Referral to the state exchange call center and website, or local assistors/navigators if the consumer has questions or wants help to choose another plan;
- The 800# or website of the state insurance or managed care agencies that regulate insurance plans in the state.

I. Retention of mail option for enrollees to update income information

Providing consumers with the option to report changes, renew eligibility, or take any action required by the exchange by mail is important to many older, rural and low-income consumers who have limited access to the internet, telephone and transportation. The drafters of the ACA recognized that mail is an important avenue to coverage and required exchanges (as well as Medicaid and CHIP agencies) to offer it as one of the four required modes of application (§ 1413). While we understand that no longer requiring a mail in option is a mitigation strategy for the 2015 plan renewal cycle, we do not support it as permanent regulatory change. Instead, we recommend CMS retain the regulatory requirement that exchanges allow consumers to use mail for applications, renewal or other exchange business, and not adopt the amendments provided in the proposed rule.

RECOMMENDATION – Amend proposed §155.330(b)(4) as follows:

(4) The Exchange must allow an enrollee, or an application filer on behalf of the enrollee, to report changes via the channels available for the submission of an application, as described in § 155.405(c)(2)~~, except that the Exchange is permitted but not required to allow an enrollee, or an application filer, on behalf of the enrollee, to report changes via mail~~.

RECOMMENDATION – Amend proposed §155.335(e)(2) as follows:

(4) The Exchange must allow an enrollee, or an application filer on behalf of the enrollee, to report changes via the channels available for the submission of an application, as described in § 155.405(c)(2)~~, except that the Exchange is permitted but not required to allow an enrollee, or an application filer, on behalf of the enrollee, to report changes via mail~~.

Renewals for 2016 and Beyond

We appreciate CMS' recognition that improvements are needed concerning the annual redetermination process and share CMS' goal of helping individuals keep their coverage even if they do not take action. We understand that additional flexibility may be needed for the 2015 plan year as a result of technological limitations, but strongly recommend CMS to not only think of the immediate needs for 2015, but to put in place now steps to for a more sustainable consumer-friendly framework for renewals in 2016 and beyond.

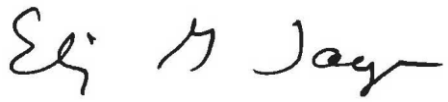
In particular, we recommend CMS implement future system upgrades so that additional and more current income data sources are used for the basis of redetermining eligibility for financial assistance. CMS should use all income-related hub data sources, such as SSA, for redetermining eligibility for financial assistance. Additionally, CMS should work toward integrating key state sources of income information, including state wage and unemployment data, that are often more timely.

We also recommend CMS set benchmarks and provide financial incentives for exchanges to develop a fully automated renewal process that redetermines eligibility for financial assistance that takes into account the move to the new FPL and the calculation of the premium subsidy based on the new benchmark plan. Automated renewals should not require consumers to contact the exchange unless they need to report a change.

Conclusion

If you have any questions or need further information, please contact Sonal Ambegaokar, Senior Attorney at ambegaokar@healthlaw.org or (310) 736-1646. Thank you for your consideration.

Sincerely,



Elizabeth G. Taylor,
Executive Director