NHeLP
NATIONAL HEALTH LAW PROGRAM

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VIA ELECTRONIC SUBMISSION

Gary Cohen
Deputy Administrator & Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Bethesda, MD

RE: Letter to Issuers on Federally-facilitated and State Partnership Exchanges

Dear Deputy Administrator Cohen:

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 review the Letter to Issuers. We submit these comments addressing our concerns and look forward to conversations with you and your staff to continue to improve the requirements for issuers to ensure compliance with the ACA and to protect consumers' rights.

Our comments address concerns with specific sections of Chapters 1, 3, 4, 5 and 6.

Chapter 1: Certification Standards for Qualified Health Plans

SECTION 1. NETWORK ADEQUACY AND INCLUSION OF ESSENTIAL COMMUNITY PROVIDERS

i. Network Adequacy

CMS should establish more robust network adequacy standards for QHPs and create a transparent monitoring system to ensure compliance and better inform consumers.

Federal regulations require QHPs to maintain a network with a sufficient number of providers "to assure that all services will be accessible without unreasonable delay." 45 C.F.R. 156.230(a)(2). However, this network adequacy standard is overly broad and will have little meaning without effective monitoring and oversight.

In its Letter to Issuers, CMS describes a myriad of ways QHPs can demonstrate network adequacy. For some QHPs, CMS will rely on state-level network adequacy reviews as part of the licensing process; for others, CMS will rely on the accreditation process; for others CMS will require QHPs to submit an access plan as part of the QHP application. CMS will also monitor network adequacy through complaint tracking.

This diffuse oversight of network adequacy and lack of uniform standards and reporting will create significant challenges in effective compliance monitoring. CMS should require all QHPs to meet and adhere to specific network adequacy standards. Medicaid managed care regulations may serve as a useful starting point for establishing a baseline of network adequacy metrics for QHPs.[1] These include reporting primary care provider-enrollee ratios, provider-enrollee ratios by specialty, hours of operation, geographic accessibility, identifying providers who are not accepting new patients, and listing the waiting times for appointments with participating providers.[2]

However, network adequacy standards in Medicaid managed care have proven difficult to monitor and enforce.[3] For this reason, CMS should establish a more robust monitoring and enforcement system that requires QHPs to publicly report compliance with network adequacy standards. Reports showing compliance with network adequacy measures including provider capacity and average wait times, should be posted in a

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[1] 42. C.F.R. § 438.206

[2] See also NAIC Health Insurance and Managed Care Committee, Plan Management Function: Network Adequacy White Paper, June 27, 2012, available at http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

[3] See Medical Care Advisory Committee (MCAC) Behavioral Health Subcommittee, *FY 2011 Report and Recommendations* (Aug. 2012) at 6, which found that the Dept. of Health Care Finance failed to monitor provider capacity and refused to provide the MCAC with monitoring reports, *available at* http://www.dcbehavioralhealth.org/news/reportscitesneedtoimprovemanagedcare.

prominent place on the QHP's website and be updated periodically (at least on a quarterly basis). The website for the Marketplaces should also link to these reports. QHPs should also provide its network adequacy reports to consumers along with the Summary of Benefits and Coverage (SBC). CMS and states should monitor QHPs for compliance and conduct random audits to verify the data reported.

QHPs will be more likely to meet and adhere to network adequacy standards if they are required to publicly report their compliance. Moreover, information such as average wait times for appointments will be useful to potential enrollees when selecting a QHP.

CMS should establish uniform network adequacy standards and methodologies because state models may be insufficient. If a state's assessment of network adequacy does not evaluate whether the essential health benefits are actually available to enrollees without unreasonable delay or travel, CMS should not rely on the state's findings of network adequacy. A standard that merely counts the numbers and types of providers should not be considered sufficient. Before relying on state reviews, CMS must ensure that states account for the range of services offered by participating providers, and whether providers are accepting new patients. If an enrollee needs contraception, for example, but her plan only offers OB/GYNs who perform pelvic exams and provide prenatal care but are personally opposed to contraception, the services she needs are not actually accessible to her. Similarly, if an enrollee needs primary care, but his plan does not offer any primary care providers who are accepting new patients, the services he needs are not actually accessible to him. Additionally, before relying on state findings, CMS should ensure that state assessments include evaluation of appropriate travel times and distances that account for variation in specialty type and geography.

Particularly in states without sufficient network adequacy review, CMS should conduct its own thorough review, ensuring that the provider network of each QHP is sufficient in numbers and types of providers to assure that all covered services will be accessible to enrollees without unreasonable delay or travel. While CMS can take an issuer's accreditation into account when conducting its review, it should not be sufficient to show compliance.

ii. Essential Community Providers

The Minimum Expectation of only 10% articulated in this letter is unreasonably low and does not guarantee a sufficient number and geographic distribution of providers to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area as required under the law. At a minimum, all issuers should be required to meet the Safe Harbor standard articulated in the letter. If an issuer fails to meet the Safe Harbor standard, the issuer should be required to show a good faith effort to contract with the required numbers and categories of essential community providers. The issuer should also provide a narrative description of how the insurer's provider networks, as currently designed and after taking into account new 2014 enrollment, provide an adequate level of service for low-income and medically underserved

enrollees. It should be difficult for issuers that do not meet the Safe Harbor requirements to meet the regulatory standard.

Further, the Safe Harbor standard itself must be strengthened in order to fulfill the regulatory requirement that qualified health plans include "a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers." Under the standard outlined in the Letter, issuers must offer contracts *during the first coverage* year to at least one ECP in each ECP category in each county, in addition to demonstrating that 20 percent of available ECPs in the service area are included in network.

It is imperative that HHS revise this standard to ensure issuers are offering contracts prior to QHPs being available on the Marketplace in October 2013. Allowing plans to meet the Safe Harbor by simply offering a contract *during the first coverage year* does nothing to ensure that patients entering the Marketplace in 2013 will have access to providers. Instead, we recommend that issuers must to offer a contract *before the start of the coverage year*. Likewise, consistent with the expectation HHS outlined in the Final Exchange Rule, the Letter should make clear that those contracts must be meaningful in that they include all of the services the plan covers and the ECP provides and offer reimbursement at generally applicable payment rates. In addition, HHS must revise the standard to increase the number of ECPs per category per county and, at minimum, increase it to at least 3 ECPs per category per county.

iii. Alternate ECP Standard for Integrated Issuers

As stated above, we do not believe the Minimum Expectation standard is sufficient to guarantee the required number and geographic distribution of providers to ensure reasonable and timely access for low-income, medically underserved individuals.

SECTION 2. ACCREDITATION

The Letter to Issuers mentions that CMS is adopting a phased approach to accreditation, as stated in the final Essential Health Benefits (EHB) rule. We urge HHS to provide further subregulatory guidance on the EHB rule. In particular, HHS should issue further guidance on provision of the EHB and the "substantially equal" standard maintained in the EHB final rule to ensure issuer compliance.[4]

In § 156.115(a)(1) of the final rule, HHS suggests that insurers will be considered in compliance with EHB coverage requirements so long as they provide benefits that are "substantially equal" to the EHB benchmark plan. The use of "substantially equal" terminology creates an additional loosening of the EHB standard which has no basis in law and threatens to further weaken an EHB standard. This concern is exacerbated by

[4] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12834 (Feb. 25, 2013) (to be codified at 45 C.F.R. parts 147, 155, 156).

the fact that HHS provides no guidance or framework for analyzing whether covered benefits or limits on coverage meet the "substantially equal" standard. NHeLP previously recommended that HHS eliminate this language. The final rule retains this language. Therefore, HHS must set a strong standard for "substantial equivalence" and will need to monitor this proactively.

The EHB final rule also expressly allows insurer flexibility to substitute benefits within a category of services if they meet certain actuarial equivalence requirements. Although NHeLP strongly disagrees with this substitution policy, we commend HHS for at least limiting the substitutions within categories, as opposed to across categories, which would be even more problematic. We urge HHS to issue further guidance to issuers and states outlining the limits on substitution authority, as well as the procedures that must be in place to ensure that all substitutions are adequately reviewed and monitored for compliance with other QHP and EHB requirements, including nondiscrimination and actuarial equivalence. Allowing insurers to substitute services creates dangerous potential for discrimination and insurance rating through benefit design. The EHB standard should serve as a floor, not a ceiling. We once again urge HHS to eliminate any provision for issuer substitution. It completely undercuts the letter and intent of the ACA in a number of areas, including nondiscrimination and meaningful coverage of the ten statutory benefit categories.

Subregulatory guidance on benefit substitution should also reiterate the following protections created by the EHB final rule, including:

- Exclusion of drug coverage from substitution;
- State flexibility to limit or eliminate substitution; and
- A general prohibition to prevent plans from excluding enrollees from any category of coverage.

We appreciate the additional guidance provided on EHB prescription drug coverage, including the detailed process outlined in Appendix C for the prescription drug exceptions process. We urge HHS to require that where an individual is experiencing a serious health condition, or where any delays in immediate access to the drug could cause harm, the issuer must provide a decision as soon as possible, and absolutely no later than 24 hours after receiving the request. We appreciate HHS' recognition that plans offering the EHB should allow the enrollee to have the medication in dispute during the entire review process and, when the exception request is granted, during subsequent plan/policy years.

SECTION 4. BENEFIT DESIGN REVIEW

i. Non-discrimination

We recommend that CCIIO include additional information regarding nondiscrimination requirements in the Letter to Issuers. We support the language CCIIO has already

included that QHPs must attest they will not discriminate on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation, consistent with 45 C.F.R. § 156.200(e). To ensure that QHPs do not employ market practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs, we believe a deeper analysis, beyond a cost-sharing analysis, will be required and recommend CCIIO set up standards to do so. CCIIO should look beyond cost-sharing and compare actual benefit designs for outliers on limits and restrictions, such as visit limits and prior authorization requirements, associated with specific benefits.

In particular, four provisions in the ACA specifically relate to nondiscrimination and CCIIO should specifically require compliance with them:

- § 1557 prohibits discrimination on the basis of race, color, national origin, language, sex, sexual orientation, gender identity, age and disability in health programs or activities that receive federal financial assistance, are administered by an Executive agency, or were established by Title I of the ACA.
- § 1302(b)(4)(B) requires that the Secretary "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life."
- § 1302(b)(4)(C) requires the Secretary to "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups."
- § 1302(b)(4)(D) requires the Secretary to ensure "that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or the individuals' present or predicted disability, degree of medical dependency, or quality of life."

These four provisions provide CCIIO ample authority to implement stronger provisions to prevent discrimination.

RECOMMENDATION: Add specific information regarding the nondiscrimination requirements with regards to EHB:

> 45 C.F.R. § 156.125, which codifies § 1302(b)(4) of the Affordable Care Act, prohibits issuers providing EHB from employing or implementing benefit designs that have the effect of discriminating against individuals based on age, expected length of life, present or predicted disability, quality of life, or other health conditions. Similar to other EHB standards, the nondiscrimination requirements are subject to state enforcement. QHPs seeking Exchange certification must meet additional non-discrimination standards generally related to plan cost sharing.

CMS will conduct a non-discrimination analysis on EHB where a state is not enforcing these standards. Each Exchange will be responsible for enforcing non-discrimination standards for QHPs. Where CMS is reviewing EHB coverage for non-discrimination, CMS will compare benefit designs for outliers on the limits and restrictions, such as visit limits and prior authorization requirements, associated with specific benefits.

Additionally, we support the review procedure proposed by CCIIO, whereby information contained in the "explanations" and "exclusions" sections of plans is reviewed to identify discriminatory practices or wording. It is of particular importance, as the draft Letter describes, that exclusions or limitations that reduce the generosity of benefits for subsets of enrollees without clinical rationale are flagged for review. We recommend that CCIIO provide more specific information regarding the standards for identifying types of exclusions or limitations that will result in review of benefits designs utilized by issuers. Examples of discriminatory benefit designs may include:

- Exclusions for otherwise-covered services for cases other than those in which the purpose of the treatment is to recover lost functioning or to restore previous levels of functioning. Such exclusions have a disparate impact on individuals with developmental disabilities who rely on services to attain certain functions or to avert their loss or deterioration. While the Affordable Care Act requires coverage of both rehabilitative and habilitative care, this requirement will mean little if issuers are permitted to continue to employ limited ideas of how broad the range of services covered under the category of habilitative care must be.

- Restrictions on "medically necessary" treatment within a benefit category to cases in which the services are required for the treatment of "illness, injury, diseased condition, or impairment." This type of limitation is frequently used to deny coverage for health conditions classified as being present at birth rather than the result of a disease process.

- Exclusions for otherwise-covered benefits such as mental health services when provided for the purpose of treating eating disorders. These exclusions carve out coverage explicitly on the basis of health condition, and they also disproportionately impact women, who are more likely to develop eating disorders than men.

- Exclusions for otherwise-covered benefits when provided for the purpose of treating Gender Identity Disorder, gender dysphoria, or related conditions. These transgender-specific exclusions contradict the consensus of leading professional medical associations regarding the medical necessity of these treatments for many patients, and they unacceptably limit access to otherwise covered benefits on the basis of health condition and gender identity.

- Exclusions for the treatment of infertility. Infertility affects an estimated 12% of women of childbearing age, and infertility treatments are more commonly prescribed for women than for men.

- Exclusions for mental health, substance use disorder, and behavioral health treatments that fail to meet the parity standards required by the Mental Health Parity and Addition Equity Act of 2008 (MHPAEA). Despite these existing parity requirements, state implementation and enforcement of MHPAEA has varied widely. Additionally, patients seeking mental health services are frequently subjected to excessive and inappropriate non-quantitative limitations.

Ultimately, any standard utilized by CCIIO in this assessment must make clear that the determination of whether a coverage limitation or exclusion is discriminatory turns on the degree to which the benefit design is based on sound standards of clinical appropriateness rather than on arbitrary distinctions between health conditions or personal characteristics.

Chapter 3: Qualified Health Plan Performance and Oversight

SECTION 3. QHP MARKETING

We strongly support the requirement that QHPs must ensure that all marketing products and materials meet the meaningful access standards. We make further recommendations to the specific meaningful use requirements, cross-referenced in this section, below.

Chapter 4: Stand-Alone Dental Plans

The Letter indicates that in each state with an FFE, a standalone dental option to provide the essential pediatric dental benefit is expected. This means that issuers of QHPs will not be required to provide a pediatric dental benefit integrated within a QHP.

FFEs should ensure that consumers in all states have access to one or more QHP option that includes an integrated pediatric dental benefit and any other essential health benefits. People receiving premium and cost-sharing subsidies should be able to select a plan that covers the basic set of essential health benefits and should not be required to pay more out-of-pocket for additional coverage that is unsubsidized. If CMS does not require integrated QHP options in all states, CMS should then ensure that consumers will have access to at least one standalone pediatric dental option. Of course, if consumers want to pay additional premiums in order to get adult dental coverage, that option should also be available. But, particularly for those receiving subsidies, the structure of plan offerings should not require people to pay more for coverage above and beyond what they must already contribute toward their premiums and other out-of-pocket costs.

We note that comparing plans and understanding what to purchase and how much it will cost is likely to be far more complicated for people because of standalone dental coverage. It will be crucial for consumers to get clear information about the key decisions they must make, particularly the fact that in some cases the price for a standalone dental plan displayed on the FFE website may not be an actual price and that consumers could face additional underwriting that would result in higher costs if they actually enroll in the plan.

Chapter 5: Consumer Enrollment and Premium Payment

From the perspective of many LGBT individuals, a particularly important consideration in health reform implementation is whether "family" coverage offered by QHPs may include same-sex partners and spouses and their children. The issue of coverage equivalence for same- and different-sex couples and the legal situation of their children are particularly important in the FFE and Partnership states[5] where same-sex marriage is now legal, and in the additional states[6] where other forms of relationship recognition exist for same-sex couples. Furthermore, even in states where there are explicit prohibitions on the legal recognition of same-sex relationships,[7] insurers still frequently extend coverage to domestic partners,[8] and some states give carriers the explicit authority to offer benefits to these couples.[9] As a matter of state law, same-sex partners in many FFE and Partnership states may thus currently be eligible to enroll in family coverage, regardless of whether their relationship is recognized by state law.

While regulations issued by the Treasury Department make clear that the Defense of Marriage Act (DOMA) prohibits same-sex couples from applying jointly for advance premium tax credits to purchase coverage through the Exchanges, families headed by same-sex couples should be able to apply any individually-calculated credits to purchase any family coverage offered by QHPs. Therefore, we strongly recommend that the letter to issuers make clear that eligibility for family plan enrollment may nonetheless be provided on an equal basis for same-sex partners as with those in different-sex relationships. Additionally, guidance to issuers provided by this letter should make clear that family coverage also includes any parent-child relationship recognized under state law.

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[5] IA, ME, NH – which will have Federally-Facilitated Partnership Exchanges - all permit same-sex couples to marry on the same terms as opposite-sex couples. Several states that will be running their own Exchanges – CT, DC, MA, MD, NY, VT, and WA – are also states where same-sex couples are able to marry on the same terms as opposite-sex couples.

[6] DE, IL, NJ, and WI – which will have Federally-Facilitated Partnership Exchanges - all have some other form of relationship recognition for same-sex couples. Several states that will be running their own Exchanges –CA, CO, HI, NV, OR, and RI – are also states offering some non-marital form of relationship recognition for same-sex couples.

[7] *See e.g.* Nebraska State Constitution Article I-29.

[8] For example, a search performed on the www.healthcare.gov for individual coverage for two men in zip code 68776 (South Sioux City, Nebraska) resulted in 17 hits for plans offering coverage to same-sex partners.

[9] *See e.g.* A.C.A. § 9-11-208(a)(3); C.R.S. 10-16-105.

RECOMMENDATION: We recommend the following language:

> Eligibility for family coverage under QHPs will be dependent on the law of the state. QHPs must comply with state laws regarding coverage extended to the composition of families related to insurance coverage. Additionally, QHPs must comply with state requirements related to parent-child relationships in establishing enrollment eligibility for children.

SECTION 3. EFFECTIVE DATE OF COVERAGE

In general, it appears that effective dates for coverage in a QHP through an FFE will align with effective dates for advanced premium tax credits (APTCs) and cost-sharing reductions (CSRs). However, we are concerned about cases when a baby is born (or placed for adoption) and enrollment in QHP coverage would be effective on the date of birth (or adoption), but subsidies would not be available until the following month. It is important to ensure that newborns can be covered promptly, and we support providing a special enrollment opportunity based on this trigger. However, we are concerned that low-income families will struggle to pay the full cost of the premium before subsidies become available, and that families with babies that have high-cost health needs during the first month of life will face high out-of-pocket costs before the child's coverage is eligible for cost-sharing reductions.

RECOMMENDATION: CMS should implement policies to ensure that premium and cost-sharing assistance begin on the date of birth.

SECTION 7. NOTICE REQUIREMENTS

One of the consequences listed for losing coverage — the "inability to participate in a special enrollment period" — should be clarified. It appears the guidance contemplates that if a person fails to pay a premium and is terminated from coverage after the three-month grace period, then such person would not qualify for a special enrollment period due to the loss of that coverage for failure to pay premiums. However, if the person experiences other circumstances during the course of the year that otherwise trigger a special enrollment period (such as a permanent move or the birth of a child), a special enrollment period would still be available as specified in the law. This should be explicitly required for issuers as well as explained in the notice provided to enrollees.

SECTION 9: DIRECT ENROLLMENT WITH THE QHP ISSUER

We agree that a consumer who approaches an issuer directly should have the ability to work with that issuer to enroll in coverage "through the exchange," provided that the issuer meets certain conditions and follows specific procedures. As stated at 45 CFR §156.265(b), one of the requirements for QHP issuers seeking to enroll a qualified individual directly is to either direct the individual to file an application with the exchange in accordance with §155.310 or to ensure the applicant received an eligibility

determination for coverage through the Exchange Internet Web site. We interpret this to mean that people who approach a QHP issuer directly (or who are approached by a QHP issuer) would, prior to selecting a plan, be given access to the Exchange Web site and related tools, as well as the array of other QHP options available including those from other issuers.

Consumers (especially those who are satisfied with the issuer of health insurance coverage they already have) could always decide to enroll directly with that issuer, while still receiving any APTCs and CSRs to which they may be entitled. However, this should be an active choice that is made by the consumer with full awareness that he or she is bypassing evaluation of plan options from other issuers and the use of plan-comparison tools available at the exchange. Issuers should not have the ability (through an electronic interface or other means) to send a consumer "to the exchange" only for an eligibility determination while still in effect keeping the person on the issuer's own website and viewing only the issuer's plan offerings, without any access to the exchange website or other issuers' plans. The exchanges are required to have a number of functions and capabilities, and connecting people with the eligibility process is only one of them. Exchanges also must make multiple coverage options available to people and make it easier for consumers to compare plans. This is designed to make the individual insurance market more competitive and consumer-friendly than it is today. These goals of the Affordable Care Act will never be achieved, though, if insurers are able to enroll people in subsidized QHP coverage without ever exposing them to the exchange and the competitive plan options it makes available.

If CMS is planning to set up an electronic interface to help issuers directly enroll people "through the exchange," issuers should be required to abide by a number of additional consumer protections. They should have to display a standard, clear message to inform consumers that they are not at the exchange but do have the option to go to the exchange. This message should state that the consumer would be able to compare various plans from additional insurance companies at the exchange. This standard message should use whatever the proper name of the exchange is in the state where the consumer is located. Issuers should be required to display the message at set points in the process, particularly at the beginning of the interaction with the consumer and immediately after the eligibility determination is completed, precedes plan comparison and selection.

If plan enrollees approach an issuer to report a change in circumstance that could affect eligibility or the amount of exchange subsidies, the issuer should direct the person to report the information to the exchange. If the enrollee is eligible for a special enrollment period, the exchange should provide complete information about the terms of the special enrollment period, the ability to select a new plan from a new issuer, to change plan coverage levels, and the consequences of a decision to change issuers (including the advantages of remaining with the same issuer if the person is reporting the change in the middle of the year and has already paid cost-sharing charges to that issuer). The consumer should not be automatically sent to the issuer's web site without being fully

informed of his or her special enrollment rights and the opportunity to view plans and consumer tools at the exchange.

Chapter 6: Consumer Support

SECTION 1. CALL CENTER AND WEBSITE

To ensure that individuals who are limited English proficient and individuals with disabilities can have meaningful access to QHPs' websites and call centers, we strongly believe the Letter to Issuers must include specific requirements for these QHP functions. Call centers must provide oral communication assistance to LEP consumers in all languages and also offer assistance to individuals with disabilities who may use relay services.

We also recommend that QHPs translate their websites into Spanish and the top two other most prevalent languages for their enrollees and provide a language portal with information in up to 15 languages informing LEP individuals how to access assistance. Websites should also inform individuals with disabilities how to access augmentative or assistive communication devices, sign language interpreters and materials in large print/Braille/alternate formats.

RECOMMENDATION: Add the following language into this section:

> The Call Center will provide oral communication assistance to individuals with limited English proficiency through use of competent bilingual staff or competent over-the-phone interpreting. The Call Center will also be competent to assist individuals with disabilities. As one of the primary channels for communication with the consumer, the Call Center will be available twenty four hours a day, seven days a week. Where possible, the customer service representatives at the call center will be able to provide referrals to the appropriate state or federal agencies or assistance programs (e.g.., Navigators, in-person assistors), or issuers.
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> The website must be translated into Spanish and the next top two languages prevalent in the QHP's service area. The website must also include taglines or a language portal directing individuals who are limited English proficiency how to obtain language service including both written translations of materials and oral communication. QHPs must provide taglines or language portals that include at least fifteen languages. The website must also inform individuals with disabilities how to access augmentative or assistive communication devices, sign language interpreters, and materials in large print/Braille/alternate formats.
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> SECTION 2. CONSUMER EDUCATION

We strongly support the requirement that QHPs must ensure that all educational, marketing, and plan materials comply with the requirements for meaningful access. We make further recommendations to the specific meaningful use requirements, cross-referenced in this section, below.

SECTION 3. PROVIDER DIRECTORY

We support the requirements for a provider directory and the encouragement of including the languages spoken. We do suggest that issuers ensure that any provider that includes a language spoken by the provider or his/her staff have sufficient language competency in that language. Effective communication depends on actual language proficiency and competency. If a member of the provider's staff has the language competency and is going to interpret for the patient and provider, the staff person must have sufficient knowledge, skills and training as an interpreter. According to the HHS Office for Civil Rights in its "LEP Guidance," being bilingual alone is not sufficient to interpret. Thus, if a provider is going to list the languages spoken in the office, the QHP should ensure the language skills are sufficient that if an LEP individual selects that provider, the LEP individual will be able to effectively communicate. We also encourage QHPs to designate if the language spoken is by the provider, who thus could provide services directly in the non-English language, or by the provider's staff, in which case the staff would serve as interpreters for the provider. The QHP could require language testing for providers as a pre-condition for listing a language in the provider directory and interpreter training if a provider will use bilingual staff to communicate with LEP patients.

We also strongly recommend that CMS require issuers to identify providers who have accessible equipment for individuals with disabilities

RECOMMENDATION: Amend the requirements regarding provider directories to read as follows:

> . . .CMS encourages issuers to include information such as whether the provider is accepting new patients, languages spoken, provider credentials, ~~and~~ whether the provider is an Indian provider*, and detailed accessibility information (e.g., "exam table lowers to __ inches," "platform scale available for wheelchair users," "bathroom meets ADA Accessibility Guidelines," "transfer assistance provided upon request," "alternative formats such as Braille, large font or electronic disc or mail available upon request," "Sign language interpretation available upon request," "examination room with __ turning radius available upon request," and/or "extended appointment time available upon request when facilitated communication is required in the appointment.") At the very least, provider directories will provide contact information for customer representatives who will assist health plan members and the public to determine whether and which network providers have the accessibility features that a member or perspective requires to receive effective health care services.*

RECOMMENDATION: Require issuers to assess (or providers to verify) language proficiency and interpreter competency prior to including information in the provider directory about language.

SECTION 4. COMPLAINTS TRACKING AND RESOLUTION

NHeLP applauds CMS' proposal to track consumer complaints and to aggregate information contains in complaints to help direct oversight activities in FFEs and State Partnership Exchanges. Information suggesting issuer performance problems could also be useful to consumers, particularly at the point of plan selection. Some states currently compile and publicly report information on grievances and appeals filed against health plans.[10] CMS should make complaint tracking publicly available by requiring QHPs and exchanges to post aggregated complaint reports on their websites and in a prominent location. This will promote transparency and also allow consumers to evaluate QHPs based on the number and resolution of complaints.

SECTION 6. MEANINGFUL ACCESS

We strongly support including information on meaningful access for individuals who are limited English proficient (LEP) and individuals with disabilities. However, we believe the final letter fails to provide sufficient information to issuers to understand the depth and breadth of assistance they must provide. We strongly support specific, detailed requirements as individuals whose health and lives are at stake – which the case when they are accessing healthcare services – must be able to actively participate and communicate with their insurers and healthcare providers. Without such accessibility, issuers will likely offer substandard assistance to certain groups of individuals who are potentially at the highest risk of needing assistance.

These requirements apply to issuers' activities pursuant to Title VI of the Civil Rights Act of 1964, the Rehabilitation Act, the Americans with Disabilities Act and section 1557 of the Affordable Care Act. Title VI, the Rehabilitation Act and section 1557 all apply because issuers will be subcontractors to Exchanges which are subject to these laws. Additionally, issuers are recipients of federal financial assistance by accepting federal funding to help pay the premiums and cost-sharing for lower-income individuals participating in the Exchanges. Further, section 1557 applies to the issuers since Exchanges are created under Title I of the Affordable Care Act and Exchanges are created under Title I. It would be an absurd result if the Exchanges themselves are subject to § 1557 but not their subcontractors. For more information on the applicability of section 1557 to the Exchanges, see NHeLP's Short Paper 6: The ACA and Application of § 1557 and Title VI of the Civil Rights Act of 1964 to the Health Insurance Exchanges.

[10] Reports issued pursuant to New Jersey Health Quality Act are available at http://www.state.nj.us/dobi/division_insurance/managedcare/ihcapreports.htm

Courts have recognized that providing information in English to a poorly educated, non-English speaking individual without a translation or oral interpretation of the information contained results in "procedural unconscionability."[11] Given the complex nature of these interactions, including the new processes for interacting with QHPs by many individuals who have not previously had insurance, we believe the same procedural unconscionability would result if meaningful access processes are not developed and implemented in such a way as to ensure LEP individuals and individuals with disabilities could effectively navigate and access healthcare.

Due to the legal precedent, as well as the stated goals of health reform of including everyone, we strongly recommend that HHS adopt and include in the Letter specific detailed requirements to provide effective communication with LEP individuals and individuals with disabilities

RECOMMENDATION: Substitute the following for the current section on meaningful use:

> In order to ensure meaningful access by limited-English proficient speakers and by people with disabilities, the Exchange Final Rule requires that QHP issuers provide all applications, forms, and notices to enrollees in plain language and in a manner that is accessible and timely to individuals living with disabilities and individuals with limited English proficiency. (*See* 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250). Additionally, 45 C.F.R. § 1 56.200(e) prohibits QHP issuers, with respect to QHPs, from discriminating on the basis of race, color, national origin, or disability.
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> Certain Federal civil rights laws also apply to QHPs. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin (including primary language) by entities that receive Federal financial assistance. Section 504 of the Rehabilitation Act of 197325 includes an obligation to provide individuals with disabilities an equal and effective opportunity to benefit from or participate in a program receiving Federal financial assistance or under any program or activity conducted by a Federal Executive Agency.

[11] *Cisneros v. American General Financial Services*, No. C 11-02869 CRB, (U.S. Dist., N.D. CA, July 24, 2012). This case involved a Spanish-speaking individual signing an Account Agreement and Sales Slip that contained notice and description of an arbitration provision were entirely in English. The sales agent did not verbally translate the forms, provide Spanish versions of the forms, or even alert Plaintiff to the arbitration clause. Id. The Defendant cited to an unpublished case from this District to emphasize the duty to read contractual terms even with a language barrier, the case cited deals with two sophisticated merchants. See *Chateau des Charmes Wines Ltd. v. Sabte USA, Inc.*, No. 01-4203, 2002 WL 413463, at *3 (N.D. Cal. Mar. 12, 2002), rev'd on other grounds sub nom. *Chateau des Charmes Wines Ltd. v. Sabate USA Inc.*, 328 F.3d 528 (9th Cir. 2003). In the *Cisneros* case, however, the plaintiff's inability to understand arbitration terms because they were written in English increased the procedural unconscionability of this contract.

To assist QHP issuers in complying with the standards established in 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250, we outline a safe harbor approach for issuers. QHP issuers can satisfy meaningful access standards by implementing the measures described in the following paragraphs.

Safe Harbor Measures: The measures outlined in this paragraph are evidence of compliance with the regulatory requirements established by 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250.

Language Access

- Applications and notices, as described in the list below, produced or used by QHP issuers should be available in the languages spoken by the state's top ten largest LEP groups or spoken by 10,000 persons or greater, whichever yields the greater number of languages. Said documents should also include taglines in the top 30 non-English languages in the state indicating the availability of free language assistance services through a QHP issuer's call center.
- QHP issuers should offer oral interpretation, such as through telephonic interpreter services via a call center, in 150 languages, for notices and applications.
- QHP issuer Websites that contain information about QHPs, including applications and notices, should have taglines in the top 15 non-English languages in the state indicating the availability of free language assistance services through a QHP issuer's call center. Websites with content in English should be translated into Spanish, and applications and notices appearing on issuer Websites should meet the standards above.

Access for Individuals with Disabilities

- Applications and notices, as described in the list below, must be provided, as requested, in alternate formats, including Braille, large print, or another effective method of making visually delivered materials available to individuals with disabilities, including individuals who are blind and who have low vision.
- Applications and notices, as described in the list below, should be in plain language and presented at or below the 6th grade proficiency and comprehension level.
- Call centers operated by QHP issuers must include telecommunications relay services to effectively serve persons who are deaf and hard of hearing.
- QHPs are required to inform consumers of the availability of auxiliary aids and services such as qualified interpreters, note-takers, and materials in alternate formats.
- QHPs must provide auxiliary aids and services at no cost to the consumer.
- Websites and electronic documents must be compatible with screen reader software.

- Websites and electronic documents must meet Section 508 standards or standards that provide greater accessibility to persons with disabilities.

QHPs are reminded that these meaningful access requirements are independent of other obligations QHPs may have, but also interact with those other obligations. For example, there are specific requirements relating to Essential Community Providers who are Integrated Issuers, requiring them to describe the extent to which provider sites are accessible to specific underserved populations. One of those populations is "low-income and underserved individuals seeking women's health and reproductive health services." The general inaccessibility of mammography machines and reproductive services to low-income women with mobility disabilities is well-documented, and certainly constitutes a lack of "meaningful access" within this specific underserved population group. Moreover, people with disabilities do not have meaningful access overall to health care services if QHP provider networks are physically and programmatically inaccessible, or if providers discriminate by failing to offer reasonable accommodations and policy modifications, such accessible equipment, modified appointment times, assistance with filling forms, and sign language interpreters, to people with various disabilities. In terms of meaningful communication access, and in accordance with 45 C.F.R. §§ 155.205(c), 155.230(b), and 156.250, meaningful access includes but is not limited to the use of accessible websites and the provision of auxiliary aids and services in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

A QHP issuer that does not implement the safe harbor measures may demonstrate compliance with meaningful access standards by developing and submitting a plan or strategy to provide meaningful access for persons with limited English proficiency and persons with disabilities.

QHP issuers that implement the safe harbor measures are also encouraged to develop and submit such a plan. The plan or strategy should include at least the following:

- How to identify persons with limited English proficiency or with disabilities;
- The types and extent of assistance services available;
- How to provide notice to persons with limited English proficiency or with disabilities of the availability of appropriate assistance services;
- How to communicate with persons with limited English proficiency or with disabilities on the phone, in writing, and in person;
- A schedule and process for monitoring and updating the plan; and
- Training of new and existing staff in providing appropriate assistance services to persons with limited English proficiency.

CMS expects that QHP issuers will ensure meaningful access to at least the following essential documents:

- Applications (including the single streamlined application),
- Consent, grievance, and complaint forms, and any documents requiring a signature,
- Correspondence containing information about eligibility and participation criteria,
- Notices pertaining to the denial, reduction, modification, or termination of services, benefits, non-payment, and/or coverage,
- A plan's explanation of benefits or similar claim processing information,
- QHP ratings information,
- Billing notices and financial statements,
- Rebate notices, and
- Any other document that contains information that is critical for obtaining health insurance coverage or access to care through the QHP.

Furthermore, QHP issuers must inform individuals of the availability of the services described above, instruct LEP consumers and consumers with disabilities how to access these services and supports, and indicate to applicants and enrollees that said services will be provided at no cost to them.

Conclusion

In sum, we are encouraged that the Letter to Issuers does include some requirements related to nondiscrimination and meaningful access. But given the explicit requirements of the ACA, we believe the Letter should include more explicit requirements to ensure compliance with civil rights and other requirements. If you have questions about these comments, please contact Mara Youdelman, youdelman@healthlaw.org, (202) 289-7661. Thank you for consideration.

Sincerely,

Emily Spitzer
Executive Director