



September 28, 2011

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

**RE: CMS-9989-P**

**Patient Protection and Affordability Care Act; Establishment of Exchanges and Qualified Health Plans**

Dear Sir/Madam:

The Legal Aid Society and Empire Justice Center write jointly to provide comments on the Proposed Rule entitled "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans," published in the Federal Register on July 15, 2011 (76 Fed. Reg. 41866). We support the overall thrust of the proposed regulation, which is to provide State-based competitive market places that will improve individuals' choice of affordable health insurance. We strongly believe that with the implementation of the new health reform law it is critical to ensure that the Exchanges facilitate appropriate coverage for all populations, including diverse and vulnerable populations. For these reasons we are pleased to offer our comments.

The Legal Aid Society is the oldest and largest direct provider of legal services to low-income people in the United States. The Society's Health Law Unit provides direct legal services to uninsured and underinsured low-income health care consumers and beneficiaries from all five boroughs of New York City, and technical advice to advocates throughout New York State. Our advocates provide assistance on a broad range of health-related issues involving access to care and navigation of the public health insurance system. We also participate in statewide and federal advocacy efforts on a variety of health law and policy issues. The Legal Aid Society's Community Development Project provides assistance to low-income small businesses and non-profit organizations in New York City.

Empire Justice Center is a not-for-profit law firm dedicated to making systemic change to improve quality of life for low-income New Yorkers. Empire Justice provides direct

representation for clients and technical assistance and support for advocates in upstate New York and on Long Island in a wide variety of poverty-related issue areas, including health care access. Our impact work includes class action litigation and administrative and legislative advocacy.

We want to begin by expressing our gratitude to national and state consumer organizations such as the National Health Law Program (NHeLP), the Center for Budget and Policy Priorities, Families USA, and Health Care for All New York (HCFANY) for their work convening discussions and providing a valuable framework for the comments we submit today.

## **Part 155: Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act**

### **Subpart B: General Standards Relating to the Establishment of an Exchange by a State**

#### ***§ 155.105 – Approval of a State Exchange***

We support adoption of a formal process and time line for reviewing state Exchange plans. However, we are concerned about adopting the process currently utilized for State Plan Amendments (SPA) in Medicaid and Child Health Plus given the very short time frame that states are working with to get their Exchanges up and running. While we appreciate the transparency involved in the SPA process, particularly in New York where new state legislation requires Web posting of state plans and amendments, the process is incredibly lengthy. The SPA process allows 90 days for initial review, with automatic 90 days extensions if further information is received from the state. In addition, the clock stops while HHS waits to receive requested information.

States need a much more nimble system for approval of their plans. In many states, including New York, authorizing legislation has not yet been passed, which means that huge amounts of work will need to be compressed into several months. If policy makers are forced to wait a minimum of three months for a federal response on a plan, the task will become impossible.

**RECOMMENDATIONS:** We recommend that federal comments issue within 30 days of the initial submission of a state's Exchange plan. Significant changes to an approved plan could be subject to longer turnaround periods, since ongoing operations would not be interrupted. The process must be transparent to consumers. Exchange plans and revisions to Exchange plans should be posted on the internet, with mechanisms in place to collect public comment.

#### ***§ 155.110 - Entities Eligible to Carry Out Exchange Functions***

We believe HHS should provide strong guidance to states regarding conflict of interest requirements. We support the proposal to require Exchanges to publish guiding governance principles that include ethical and conflict of interest standards. Disclosures of financial interest by members of the governance structure should be required and posted for public consumption.

The federal government should require that a minimum of two-thirds of Board members be free of conflicts of interest. Anyone who works for or represents an entity that sells insurance, either inside or outside of the Exchange, should not be permitted to serve on the Exchange Board.

**§ 155.130 - Stakeholder Consultation**

We support the list of key stakeholders HHS would require the Exchange to consult on an ongoing basis, including consumers and advocates who assist with enrolling “hard-to-reach” populations. This provision of the federal law is crucial to maintaining open lines of communication between health plans, consumers, and providers and ensures that consumers’ needs are taken into account.

We suggest HHS add to the list both consumer advocates and consumers who are not enrollees in QHPs. The latter group’s input is important in order to ascertain their needs in Exchange outreach, accessibility, and services. We also recommend that HHS codify the requirement to include advocates for individuals with disabilities and those who need culturally and linguistically appropriate services.

We also suggest that “educated health consumer” be changed or defined to say “experienced with the health insurance system.”

**RECOMMENDATION:** We recommend amending §§ 155.130(a) and (c) to include the following language:

- (a) ~~Educated~~ ***Health consumers experienced with the health insurance system who are, including both enrollees in QHPs and those who are uninsured or underinsured;***
- (c) ~~Advocates for~~ ***health consumers, particularly enrolling hard to reach populations, which include individuals with a mental health or substance abuse disorder or other disability, and advocates for individuals who need culturally and linguistically appropriate services;***

Two entities listed – health insurance issuers and agents and brokers – have potentially complex conflicts of interest. We recommend limiting the required consultation under the regulation to issuers that offer QHPs and to agents and brokers that enroll qualified individuals, employers or employees in an Exchange.

**RECOMMENDATION:** We recommend amending §§ 155.130(j) and (k) to include the following language:

- (j) Health insurance issuers ***of QHPs;*** and
- (k) Agents and brokers ***that enroll qualified individuals, employers or employees in an Exchange.***

We further recommend that HHS require Exchanges to run robust stakeholder consultation processes, including specific processes that are targeted to seek consumer and consumer

advocate input in policy decisions, including the call center, Web site, Exchange calculator, consumer assistance function, outreach and education activities, and navigators. Such a process should include public meetings, stakeholder input sessions, and submission of written comments.

***§ 155.160 - Financial Support for Continued Operations***

HHS should make it clear that states are authorized to issue broad-based fees on insurers to support the continued operations of their Exchanges, and should encourage fees that apply to both participating and non-participating providers. In addition, HHS should both authorize and encourage states to use general revenues to supplement fees to support their Exchanges, particularly in the early years of Exchange operations.

**Subpart C: General Functions of an Exchange**

***§ 155.200 - Functions of an Exchange***

HHS should make clear that states are authorized to use their Exchanges to pre-screen consumers who are not eligible for Exchange products for other programs they could qualify for, such as Emergency Medicaid or hospital charity care. Many families will be of mixed status with regard to Exchange eligibility, either because of mixed immigration status or differences in countable income. Only if state Exchanges are welcoming to all will they succeed in providing coverage to eligible members of mixed status families.

**RECOMMENDATION:** We recommend that in addition to the functions listed in this section, HHS should encourage all states to include the function of providing education and referrals to consumers who visit their state's Exchange only to learn they are not eligible for any Exchange products.

***§ 155.205 - Required Consumer Assistance Tools and Programs of an Exchange***

*(a) Call Center*

Services provided

We support the consumer assistance tools mentioned in the proposed rule. We support HHS's suggestion that an Exchange call center operate outside of normal business hours and adjust staffing levels in anticipation of periods of higher call volumes, including the weeks before and during open enrollment.

While a number of consumers will have no problems accessing services via the phone or internet, many health consumers will need an in-person encounter in order to adequately serve their needs or will need to talk to a bilingual advocate who works in the community and can help them navigate local resources. A need will remain for access to in-person and locally-based Exchange consumer assistance. We recommend that HHS require the Exchange to provide in-person assistance or delegate that responsibility to existing consumer assistance programs or community-based organizations.

We also recommend that HHS include specific requirements that these call centers be able to assist LEP consumers. HHS must ensure that oral communication assistance is provided to all enrollees who access the call center. For LEP enrollees, this will likely entail the use of competent interpreters and/or bilingual call center staff. As Exchanges are subject to both Title VI of the Civil Rights Act of 1964 (since they receive federal funds) and Section 1557 of the ACA (since they receive federal funds and are an entity created under Title I of the ACA), Exchanges must comply with these civil rights requirements. It has been a longstanding recognition under Title VI of the Civil Rights Act of 1964, reiterated with the enactment of the nondiscrimination provision in Section 1557 of the ACA, that oral communication with LEP enrollees must be provided to every individual, regardless of whether thresholds to provide written materials are met. For more details on these requirements, see HHS' "LEP Guidance" available at <http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.pdf>.

These elements should be required in addition to other requirements for free services, service adequacy, and issue competency.

**RECOMMENDATION:** We recommend amending § 155.205(a) to include the following language:

- (a) Call center. The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance ***including:***
  - (1) ***Services provided free of charge to the consumer;***
  - (2) ***Sufficient staff available to answer calls in real time during and outside of normal business hours (typically 9:00 am to 5:00 pm from Monday to Friday), with 24-hour voicemail access and message indicating calls will be returned within 24 hours;***
  - (3) ***Capacity to serve consumers in-person;***
  - (4) ***Staffing levels adjusted in anticipation of periods of higher call volumes, including the weeks leading up to and during open enrollment;***
  - (5) ***Oral language services for limited English proficient callers;***
  - (6) ***Serving the consumers listed in [proposed new section] § 155.205(d)(2);***  
***and***
  - (7) ***Staff with expertise in the issues listed in [proposed] § 155.205(d)(1).***

(b) *Website*

Use HealthCare.gov as a model

The HealthCare.gov Web site "Find Insurance Options" would work as the model for the plan comparison function for the Exchange Web site as long as it is integrated and prioritized in a consumer friendly way into the rest of the Exchange Web site instead of simply providing a link. Consumers must be able to move easily between the plan information, eligibility, and plan selection processes. Additional functions the Exchange Web site must have to serve its different purposes include:

- Uniform and searchable summaries of benefits and coverage
- Consolidated provider directories, and
- Input ability for information required to produce accurate out-of-pocket cost estimates, with privacy protections and an interface that is comfortable for consumers.

HHS should also explore including quality data such as HEDIS and CAHPS data for comparison purposes.

Require a uniform and searchable summary of benefits and coverage

In order for the QHP information list on the Web site to be useful, it must be listed in a uniform way and each plan's information must be comparable to others. For that reason, we recommend HHS require the Exchange to require QHPs to submit information on the summary of benefits and coverage required by section 2715 of the PHS ACT in a uniform manner that supports a searchable format. Consumers will get lost in the various options if Exchanges make this information available though a link from their Website to each QHP's separate Website. The summary of benefits and coverage should also include the QHPs drug formulary information.

**RECOMMENDATION:** We recommend amending § 155.205(b)(1)(ii) to include the following language:

- (ii) The summary of benefits and coverage established under section 2715 of the PHS ACT, *including drug formulary information, submitted to the Exchange by the QHPs in a uniform manner that supports a searchable format.*

Require a consolidated provider directory

Similarly, in order for the QHP provider directories listed on the Web site to be useful, they must be comparable to each other. Instead of giving Exchanges the choice to determine the best way to give potential enrollees access to the provider directory for each QHP, we recommend HHS require that Exchanges establish a consolidated provider directory through which a consumer may search for a provider across QHPs.

**RECOMMENDATION:** We recommend § 155.205(b)(1)(viii) be rewritten as follows:

- (viii) ~~The~~ *A consolidated provider directory made up of directories* made available to the Exchange pursuant to § 156.230 *through which a consumer may search for a provider across QHPs and which:*
  - (A) *identifies providers that are not accepting new patients;*
  - (B) *identifies any languages spoken proficiently by the provider or his/her staff in which care may be provided.*

Assure language access and cultural competency

We fully support HHS's requirement that Exchange Web sites must provide meaningful access to information for LEP individuals. HHS mentions that this may include providing translated information, taglines, and/or oral language assistance. This will ensure that Exchanges comply with Title VI and Section 1557. In particular, the Exchange's website must be user-friendly and accessible to everyone, including those unfamiliar with computers and the Internet, those with low health care literacy, and those who are LEP.

**RECOMMENDATIONS:** The Web site should be available in the top two non-English languages in addition to English. Whether the entire portal or only certain vital sections are translated should be determined based on the numbers of LEP individuals eligible to be served by the Exchange and the importance of the information provided.

HHS should provide more explicit requirements for Exchanges to follow to comply with this requirement. HHS should require Exchanges to translate websites at least into Spanish and the second most prevalent language in the Exchange's service area. Regardless of whether the website is translated, HHS should require Exchanges to include taglines on the home page of each Exchange's website in multiple languages which explain to LEP individuals how to access information that is not translated. This should direct consumers to call the Exchange to access oral communication of the information contained on the website or to access documents the Exchange has translated.

As an example of a tagline, California's Department of Managed Healthcare offers a sample language access notice with taglines in 12 languages.<sup>1</sup> The tagline states:

**IMPORTANT:** You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your health plan's phone number at 1-XXX-XXX-XXXX. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1-888-466-2219.

The development of the tagline is an easy process and should not involve significant cost or time. In fact, Exchanges could adopt existing taglines from other agencies or organizations for use by the Exchanges. For example, California's tagline is available in 13 languages. As another example, the Arizona Department of Economic Security has a "Language Notification Flyer" that states – "If you need this notice translated into your language, please call XXX-XXX-XXXX OR XXX-XXX-XXXX." The notice includes 23 languages – 9 of which are included in SSA's 15. Exchanges, or HHS on behalf of Exchanges, could request permission to use California and/or Arizona's taglines and a plan/insurer would merely insert its number in place of the state's numbers.

We suggest that the tagline for the Web site be adapted slightly from the above. As one suggestion, it could state:

**IMPORTANT:** You can get an interpreter at no cost to talk to you about getting health insurance. To get an interpreter or to ask about written information in (your language),

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<sup>1</sup> <http://www.hmohelp.ca.gov/library/reports/news/snla.pdf>.

call 1-XXX-XXX-XXXX. Someone who speaks (your language) can help you. If you need more help, call the State Ombuds Office at XXX-XXX-XXXX.

HHS could translate the tagline into other prevalent languages or require the Exchanges to translate the tagline into the top 15 language groups likely to use the website, using state Census data or other relevant data. The entire tagline would not have to be on the homepage of the Web site, but if it is not, then the homepage should include a direct link to the taglines and could use the name of the language as the link. For example, SSA's "Multilingual Gateway" (<http://ssa.gov/multilanguage/>) includes the names of 15 languages in English and the non-English language and when a consumer clicks on the language, the consumer is taken to a webpage with information in that language. This is a small price to pay to ensure meaningful access to the Exchanges for LEP beneficiaries.

It is also important that the information be written at a low literacy level so that individuals, and particularly LEP individuals, can understand the information. Having materials written at a low "register" (literacy level) is essential to ensure comprehension so that the provision of information is not merely pro forma but offers a real opportunity for enrollees to understand the information. Because the nature of the information is technical and complex, lower literacy levels and ADA accessible formats will benefit all consumers, even non-disabled consumers at higher literacy levels. We suggest that OCIO consult the literature and specify the literacy level at which materials will provide the maximum benefit.

**RECOMMENDATION:** Amend § 155.205(b)(2) to add at the end of (2) the text "including:" and add new subsections as follows:

- (i) Translating the Exchange's website into Spanish and the second most prevalent language plus any other language(s) in which a significant number of LEP individuals reside in the service area;*
- (ii) Taglines in at least 15 languages;*
- (iii) Links to translated documents; and*
- (iv) Information for LEP consumers about how to obtain oral language assistance.*

#### Include information about costs and appeals

The Web site should also provide information for consumers on premium tax credits, cost-sharing, subsidies and the mandate penalty as well as the appeals process for use when a consumer receives an adverse determination. All of this information should be accessible to consumers with disabilities, language access challenges and low literacy levels..

**RECOMMENDATION:** We recommend amending § 155.205(b)(1)(i) and adding a new subsection (7) as follows:

- (i) Premium, ~~and~~ premium tax credit, cost-sharing, cost-sharing reduction and exemptions from the mandate penalty information.*

- (7) Provides applicants with information in a culturally and linguistically appropriate manner about complaints and appeals on how to file a complaint, health plan grievances or appeals; and tax credit appeals.*

Require contact information for Navigators and CAPs

The Exchange Web sites should act as portals for consumers to get whatever information they need for obtaining health coverage. Consumers should be able to easily get in touch with application assisters and other assistance through the site. It is not enough that the site provide general information about Navigators and CAPs. The site should also put consumer in touch with Navigators and CAPs with accurate and up-to-date contact information.

**RECOMMENDATION:** We recommend amending § 155.205(b)(4) to include the following language:

- (4) Provides applications with ***contact*** information for Navigators as described in § 155.210 and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section.

Require personal accounts

We support HHS's proposal to require Exchange Web sites to allow applicants and enrollees to store and access their personal account information and make changes, provided that the Web site complies with the standards developed by the Secretary pursuant to section 3021(b)(3) of the PHS Act.

We also support the proposal to encourage Exchanges to develop a feature whereby application assisters are able to maintain records of individuals they have assisted with the application process.

*(c) Exchange Calculator*

We support HHS's proposal to require Exchanges to establish an electronic calculator to help individuals in comparing the costs of coverage in available QHPs after the application of any advance payments of the premium tax credit and cost-sharing reductions. A model calculator would assure calculations are made consistently across the country. We recommend that HHS develop the calculator for use by the states since the rules on tax credits and cost-sharing will be developed at the national level. States could then pass the model on to consumers to apply against the QHP premiums listed in each state's Exchange. This tool would be of tremendous value to consumers, enabling them to quickly determine the actual cost of coverage after credits are applied in each QHP.

*(d) Consumer Assistance*

We agree with the recommendation that Exchanges should have a consumer assistance function and this should be front and center in this section, and conceived more broadly to meet consumers' needs. Considering that many of those who will become eligible for health insurance through the ACA have been uninsured for at least a year, Exchanges must meet the needs of this population. Many will likely be low-income, will not have had access to employer-based coverage, will not meet the criteria to qualify for public health coverage, and will have limited English proficiency. All consumers will need additional assistance in obtaining answers to general questions about coverage, helping to get enrolled in the right program, choosing the most appropriate health plan for their needs, accessing care, and staying enrolled.

All of the tools in this section (call center, Website, outreach and education, and Navigator services) are the means for providing a first class customer service experience and therefore should be considered part of consumer assistance. Taken together, these tools will provide consumer assistance that meets consumers' needs and increases understanding of the new system.

**RECOMMENDATION:** Amend §155.205 to rename it: "Required consumer assistance program of an Exchange" and reorder subsection so that § 155.205(d) leads the section as subsection (a), as the other paragraphs in this section should all be seen as forms of consumer assistance.

- §155.205 Required consumers assistance ~~tools and~~ programs of an Exchange
- (a) ~~Call center.~~ *Consumer Assistance . . .*
  - (b) ~~Internet website~~ *Call Center. . .*
  - (c) ~~Exchange calculator~~ *Internet website . . .*
  - (d) ~~Consumer assistance~~ *Exchange calculator . . .*
  - (e) Outreach and education . . . .

Ensure assistance and information on a broad scope of issues and integrate Consumer Assistance with the Navigator function of the Exchange

We appreciate that HHS recognizes that consumer assistance must be provided to ensure that consumers will receive assistance in response to a variety of requests. HHS should provide more guidance to states on how this critical consumer assistance function will be funded and how this program fits in with the Navigator component of the Exchange.

We recommend that the Exchanges be required to respond to a broad list of issues in all consumer assistance functions, and recommend that the issues be explicitly referenced. We also support the recognition in the preamble that if an Exchange receives complaints of discrimination on the basis of race, color, national origin, disability, age, or sex that it may refer these individuals to the HHS Office for Civil Rights. However, we believe this should be a requirement rather than optional and should also include referrals for complaints of discrimination based on gender orientation or sexual identity or that HHS set up its own process to address complaints.

**RECOMMENDATION:** Amend § 155.205(d) by adding new subparagraph (1):

(d) *Consumer assistance.* The Exchange must have a consumer assistance function, including the Navigator program described in § 155.210, and must refer consumers to consumer assistance programs in the State when available and appropriate.

**(1) Assistance to consumers must cover a broad range of issues, including but not limited to:**

- (i) The types of QHPs offered in the Exchange;**
- (ii) How to compare QHPs to find the best plan for the consumers specific needs;**
- (iii) The premiums, benefits, cost-sharing, and quality ratings associated with QHPs offered;**
- (iv) How to interpret quality data and cost considerations when comparing plans;**
- (v) Categories of assistance available, including advance payments of the premium tax credit and cost-sharing reductions as well as assistance available through Medicaid and CHIP;**
- (vi) Eligibility and application requirements for available coverage;**
- (vii) Actual cost of coverage after credits are applied;**
- (viii) The application process for enrollment in coverage through the Exchange and other programs, including Medicaid and CHIP, including enrollment in, retention in, and transitions between health care coverage programs;**
- (ix) Problems related to health care services, including care and service problems, denials, delays, and claims or payment problems;**
- (x) Complaints and appeals;**
- (xi) Problems with obtaining premium tax credits or cost-sharing subsidies;**
- (xii) Exemptions from mandate penalty;**
- (xiii) Complaints regarding Exchange services;**
- (xiv) Referral of all individuals who submit oral or written complaints of discrimination on the basis of race, color, national origin, disability, age, sex, sexual orientation and gender identity to the HHS Office for Civil Rights; and**
- (xv) Referrals to other programs that aid consumers through the process of acquiring and using health insurance, when the Exchange consumer assistance program cannot help the consumer with their particular need.**

**(2) Consumers must be able to access this assistance through multiple “doorways,” including, but not limited to:**

- (i) A call center;**
- (ii) A website;**
- (iii) In-person assistance;**
- (iv) A robust referral system to navigators, community-based organizations, and other external assistors; and**
- (v) Outreach and Education activities.**

### Ensure access and information to all consumers

We believe that HHS should also specifically require that consumer assistance be provided in ways that ensure access and information for all consumers, including LEP individuals. HHS should amend § 155.205(d) to explicitly require all consumer assistance functions (call center, Website, and outreach and education activities) to be provided in a manner that ensures access.

**RECOMMENDATION:** Amend § 155.205(d) to add new subparagraph (3):

- (3) All functions of the Exchange consumer assistance program must cover the following:***
- (i) Assistance provided sufficiently throughout the service area and to all consumers, including across geographic areas, hard-to-reach populations, all age ranges, income levels, and the breadth of linguistic and cultural diversity of the service area;***
  - (ii) Assistance to all consumers, including those with physical or mental health disabilities and those with limited English language proficiency;***
  - (iii) Assisting consumers with all forms of coverage or no coverage including providing consumers who are not eligible for Exchange services with assistance; and***
  - (iv) All consumer assistance functions must be provided in plain language and in a culturally and linguistically appropriate manner including the provision of translated materials and oral assistance to limited English proficient consumers.***

### Require data collection and reporting

We also believe that HHS should require Exchanges to collect data on their consumer assistance activities to identify and address prominent problems identified by callers and to identify and achieve outreach and customer service goals. This data should be made publicly available.

**RECOMMENDATION:** Amend § 155.205(d) to add new subparagraph (4):

- (4) The Exchange must collect data on their consumer assistance program to identify and address prominent problems identified by callers and to identify and achieve outreach and customer service goals. Data that must be collected includes but is not limited to:***
- (i) Customer wait times and hang ups;***
  - (ii) Caller demographics, including race, ethnicity, language, sex and disability;***
  - (iii) Frequency and languages of oral assistance provided to limited English proficient consumers;***
  - (iv) Insurance status of all individuals helped;***
  - (v) Problems and questions consumers experience with health coverage;***
  - (vi) Coverage involved;***

- (vii) Service provided to all individuals helped;*
- (viii) Case resolution;*
- (ix) Referrals and the responsiveness of the entities on referrals;*
- (x) Caseload (cases opened, active, and closed); and*
- (xi) Provider and industry behavior.*

Quality assurance

The consumer assistance program must provide high quality, reliable information. Exchanges should be required to meet insurance business practice standards for service-quality management by monitoring and maintaining beginning-to-end services for customers. Exchanges should create a Service Quality Management, which describes its collective efforts to assess the degree of consumer satisfaction with each of the consumer assistance tools provided by the Exchange. The plan should include key service quality metrics, mechanisms for collecting and analyzing data to measure performance and public reporting of customer satisfaction data. It should also include a framework for identifying and prioritizing areas in need of attention and developing quality improvement strategies.

We recommend that HHS add language that requires Exchanges to provide service quality in its consumer assistance activities and to include a “Service Quality Management Plan.” Service quality can be defined as “the collective effect of service performances which determine the degree of satisfaction of a user of the service.” Quality is the customer’s perception of a delivered service.

**RECOMMENDATION:** Amend § 155.205(d) to add new subparagraph (5):

- (5) The Exchange consumer assistance program is required to meet insurance business practice standards for service-quality management by monitoring and maintaining beginning-to-end services for customers. The Exchange is required to meet insurance business practice standards for service-quality management by monitoring and maintaining beginning-to-end services for customers. The Exchange must create a Service Quality Management Plan which describes its collective efforts to assess the degree of consumer satisfaction with each of the consumer assistance tools provided by the Exchange. The plan must include:*
  - (i) key service quality metrics;*
  - (ii) mechanisms for collecting and analyzing data to measure performance and public reporting of customer satisfaction data; and*
  - (ii) a framework for identifying and prioritizing areas in need of attention and developing quality improvement strategies.*

*(e) Outreach and Education Activities*

Provide information to all consumers

We applaud HHS' broad goals for Exchange outreach and education to include promoting coverage for uninsured consumers, in addition to educating consumers about the Exchange.

We appreciate the recognition in the preamble that outreach should be conducted broadly in ways that are accessible to LEP individuals. HHS should explicitly require that all outreach and education functions of Exchanges be provided in a culturally and linguistically appropriate manner. HHS should provide examples of how Exchanges can accomplish this. One way to facilitate this is to utilize focus groups and other active feedback mechanisms in the web portal design process including a full array of consumers, including LEP individuals. Exchanges should also focus-test materials created or translated in other languages to ensure that the information is accurate and understandable. There are myriad examples of attempts to translate materials by unqualified individuals that result in erroneous information. Exchanges must take great care in ensuring that translations are done according to recognized standards by qualified and competent translators and not by "machine" translation.

We therefore recommend that, in the regulation itself, HHS explicitly require that all outreach and education functions of the Exchange: 1) be conducted broadly and in a way that reduces the number of individuals without health insurance coverage, 2) is accessible to people with disabilities and individuals with low literacy, 3) target hard to reach populations and specific groups, and 4) be provided in a culturally and linguistically appropriate manner.

**RECOMMENDATION:** Amend § 155.205(e) to read as follows:

- (e) Outreach and Education. The Exchange must conduct outreach and education activities *in a culturally and linguistically appropriate manner that is accessible to people with disabilities, limited English proficiency, and individuals with low literacy* to educate consumers about the Exchange, ~~and~~ to encourage participation, *and reduce the number of individuals without health insurance coverage. Activities must target specific groups including the uninsured, hard to reach populations and populations that experience health disparities due to low literacy, race, color, national origin, or disability, including mental illnesses and substance abuse disorders.*

Ensure assistance and information on a broad scope of issues and decision-making tools

We appreciate that HHS recognizes that consumer assistance must be provided to ensure that consumers will receive assistance in response to a variety of requests.

We recommend that HHS explicitly require that outreach and education functions of Exchanges cover a broad list of issues, including the issues listed in the added subsection we recommend for § 155.205(d)(1) and tools for consumer-decision making such as checklists of whether QHPs cover needed care, include needed pharmaceuticals on their pharmacy and have needed providers and facilities in their network. Outreach should target the "uninsured"—or those in need of coverage or care—instead of promoting a single coverage option. Outreach should target all those in need of coverage or care to reach a wide range of individuals whose eligibility for all insurance affordability programs can be determined by the exchange.

## Require consistent language for better understanding

We recommend that HHS require that Exchanges use the same terminology to describe medical insurance as the language used in the summary of benefits. The language to be used in the summary of benefits is addressed in separate regulations. Exchanges should be required to use what is developed there in outreach and education materials, as well.

### ***§ 155.210 - Navigator Program Standards***

#### *Language access*

HHS requested comment on any specific standards or additional guidance on how Navigator programs should provide information in a manner that is culturally and linguistically appropriate. As detailed above, we believe Navigators should be subject to the same requirements as Exchanges with regard to translating materials and providing oral assistance to LEP individuals. If Navigators provide information through a website, we also suggest Navigators include translated materials, taglines, and information on how consumers can obtain oral language services. Funding for navigator programs should include the costs of translating materials and providing oral language assistance.

#### *Assure community and consumer-focused nonprofit groups receive contracts (§ 155.210(b)(2))*

We recommend HHS require that at least one of the two types of entities serving as Navigators include a community and consumer-focused non-profit organization. In accordance with the law, Navigators specifically must exhibit qualities and expertise that would allow them to serve uninsured and underinsured consumers well. Trusted nonprofit community-based programs can reach and assist low-income and vulnerable individuals and families in a manner appropriate to the community.

#### *Licensing and certification*

We support allowing states to develop training and certification programs for Navigators. We recommend that HHS develop model materials and that Navigator entities be trained and engaged in education activities before the first open enrollment period begins.

#### *Conflict of interest*

We recommend that states be precluded from providing Navigator grants to entities that receive compensation from insurers for enrolling consumers or businesses in non-QHP plans. Commissions from insurers on any type of health coverage, both inside and outside of the Exchange create conflicts of interest.

#### *Functions*

HHS should state, in the text of the regulations themselves, that Navigators are expected to facilitate enrollment in public programs as well as Qualified Health Plans. We strongly support language in the preamble that describes Medicaid and CHIP activities by Navigators as eligible for federal funding. This language should be included in the text of the regulation as well.

#### *Start-up timeframe*

We support HHS's proposal to require that Exchanges ensure that the Navigator program is operational with services available to consumers no later than the first day of the initial open enrollment period. This timeframe is appropriate, but HHS needs to identify funding to assist states in starting up their Navigators since fee-based revenues will not be available prior to January 1, 2014.

#### ***§155.230 – General Standards for Exchange Notices***

We appreciate CMS's recognition in the preamble and proposed regulatory language requiring that applications, forms, and notices must be provided in plain language and provide meaningful access to limited English proficient ("LEP") individuals and persons with disabilities. The implementation of the various "health insurance affordability options" envisioned by the ACA presents a range of new options and operational changes that must be explained clearly to enrollees and potential enrollees for health reform to be successful. It is thus more critical than ever that all written materials be presented in a manner that will effectively communicate to the wide range of populations affected.

In order to maximize consistency, HHS should work with literacy experts to develop notice templates addressing all those Exchange program components that will be uniform to all state Exchanges, namely, information and determinations regarding tax subsidies and cost-sharing, including any options available for partial utilization of such benefits in order to reduce consumer exposure to liability during reconciliation.

The use of "plain language" will be critical in explaining the complicated concepts involved in the tax subsidies and the reconciliation process, just as it is in notices that purport to explain the various health insurance options that may be available to consumers and content that notifies enrollees of their rights. Communications geared toward LEP persons and persons with disabilities is not only desirable but required by various laws, including Section 2001 of the ACA (enacting Public Health Service Act § 2719, which requires group health plans and health insurance issuers to provide notice of appeal processes in a "culturally and linguistically appropriate manner"); Title VI -- 42 U.S.C. § 2000d, *et seq.*; ACA, Section 1557, 42 U.S.C. § 18116 (Nondiscrimination). Again, HHS templates, including translations for the LEP communities, should be provided to states in order to maximize consistency and elevate the quality of consumer communications.

While the proposed regulation incorporates the basic critical "accessibility and readability" concepts of plain language, access for LEP persons and access for persons with disabilities, we make the following suggestions for improvements. Proposed revised regulatory language is also provided.

*(a) General Requirement*

The proposed regulation requires that any notice provide “[c]ontact information for available customer service resources;” “[a]n explanation of appeal rights, if applicable;” and ” [a] citation to or identification of the specific regulation supporting the action.”

The notices should also be required to include a statement of what action the exchange intends to take. Further, rather than just a citation to the regulation supporting the action, the notice should be required to include a clear statement of the reasons for the action being taken. (*See* 42 C.F.R. § 431.210, which requires these items in notices of actions to Medicaid beneficiaries.)

In order for recipients to take any potential remedial action in the event of a denial or termination of a benefit, it will be critical for the notice to particularize the basis for the action. If information or documentation is lacking, for example, the missing information should be specifically identified and described as necessary for a favorable action.

**RECOMMENDATION:** Require all notices of action to include a statement of the action being taken and an individualized statement of the reasons for the action being taken.

Since this section applies to notices of action that will trigger appeal rights, it is a bit difficult to fully comment without seeing the regulations on appeals, which are anticipated to be included in a separate proposed regulation. Nonetheless, we note here that in the event of an action that may result in the loss of coverage a second notice should be required if the enrollee does not respond to the first notice.

**RECOMMENDATION:** Require that a second notice of action be sent if the action will result in termination of coverage and the enrollee has not responded to the first notice.

*(b) Accessibility and Readability Requirements*

The proposed regulation states that all “applications, forms and notices” be written in “plain language,” provide “meaningful access to limited English proficient individuals,” and ensure “effective communication for people with disabilities.” Use of plain language is particularly challenging in notices using health insurance terminology and describing complicated processes like reconciliation. As mentioned, we recommend that HHS provide templates for notices regarding uniform program components (tax subsidies, cost-sharing, reconciliation). In addition, HHS should identify terms for the states that have benefited from consumer testing, or conduct further tests to provide recommendations for the most accessible terms to use in describing the different forms of subsidized coverage offered by states. States with multiple public programs should be urged to individualize the references to programs, so that notices do not include boilerplate lists of hypothetically applicable programs.

In addition, to assure that ALL written communications follow the required language standards, we suggest that the language be expanded to refer to “applications, forms, notices and any other documents sent by an Exchange.”

**RECOMMENDATION:** Provide templates and guidance as to best practices when using plain language to describe health coverage and expand regulatory requirement for accessibility and readability to include “any other documents.”

In the Preamble, CMS states that there are a number of ways by which an Exchange may provide access to LEP persons or persons with disabilities and suggests several, specifically information about the availability of oral interpretation services, information about languages in which written materials are available, and the availability of different formats for persons with disabilities. CMS seeks comment as to whether the examples should be codified. We strongly support inclusion in the final rule of, at a minimum, these suggestions to assure effective communication.

Rather than just stating that there must be access for LEP individuals, we believe that the final rule should include specific requirements for translating notices and other documents into other languages when thresholds of LEP individuals in the service area of the Exchange are met. We recommend a threshold of 500 LEP individuals, or 5% of those eligible to be served by an Exchange, whichever is less. Five Hundred comes from an existing Department of Labor regulation governing group health plans. The 5% is utilized in both the DOJ/HHS LEP Guidances as well as in recently revised regulations governing marketing by Medicare Part C & D plans.

Further, all notices and other documents should be required to contain a “tag line” in a minimum of 15 languages, informing individuals how to obtain copies of the notice in their language or otherwise obtain assistance in their language. HHS should provide translations of all the notice templates it produces for states.

**RECOMMENDATIONS:** Require that all notices and other documents be translated into other languages if a minimum threshold of particular language speakers live in the Exchange’s service area; also, require tag lines in at least 15 languages be included at the bottom of all notices, informing non-English speakers of where to obtain assistance in their language.

The Exchange should keep track of non-English speakers and should provide notices in the appropriate language once the Exchange has information that an enrollee or applicant is only fluent in another language. At a minimum, once an LEP individual makes a request for materials in a non-English language, the Exchange should provide all subsequent notices or other documents to the individual in that language. HHS should provide translation templates of notices on uniform program components (tax subsidies, cost-sharing and reconciliation).

**RECOMMENDATION:** Require that notices be provided in the LEP enrollee’s language once that enrollee has requested assistance in that language.

The Departments of Health and Human Services, Labor and the Treasury (“Departments”) recently published guidance and proposed regulations under the Affordable Care Act to implement the disclosure for group health plans and health insurance issuers of the summary of benefits and coverage and the uniform glossary. The regulations herein should provide that the

terms used in all Exchange documents should be consistent with those published by the Departments.

**RECOMMENDATION:** Require that terms used in notices and other documents be the same as those published for disclosure by group health plans and health insurance issuers.

*(c) Reevaluation of Appropriateness and Usability*

This section requires that the Exchange must “reevaluate the appropriateness and usability of [documents] on an annual basis and in consultation with HHS in instances when changes are made.”

We fully support the requirement that an ongoing obligation be placed on the Exchanges to reevaluate their documents, but the language of the proposed regulation is not clear. It would appear that the intent is for an Exchange to obtain HHS approval prior to making changes in its notices or other documents, but there does not appear to be a requirement for HHS to approve the documents in the first place. Moreover, it is not clear whether the Exchange must just consult with HHS, or whether it is actually the intent that HHS must approve any changes. As it does seem like good policy for HHS to use its expertise to review Exchange notices for readability, we suggest that it be made clear that HHS must review and approve all documents and any subsequent changes to documents.

Further, we believe that, in addition to consultation with HHS, the Exchanges should be required to consult with stakeholder representatives, specifically consumers or persons who represent the interests of consumers, in regard to notice language.

**RECOMMENDATION:** Require that HHS approve all Exchange documents for readability and that HHS approve Exchange’s accessibility policies for LEP persons and persons with disabilities. Also, require that Exchanges provide an opportunity for stakeholders to review notices for readability and accessibility.

**RECOMMENDATION:** We recommend § 155.230 be written as follows:

- (a) *General requirement.* Any notice required to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers, and enrollees ***announcing an action that will impact said person’s eligibility for or benefits under a health plan*** must be in writing and include:
  - (1) ***The reasons for the intended action;***
  - (2) A citation to or identification of the specific ***law or*** regulation supporting the action;
  - (3) An explanation of appeal rights, if applicable; and
  - (4) Contact information for available ***consumer assistance*** resources.
- (b) *Accessibility and readability requirements.* All applications, forms, notices ***and other documents (hereinafter “documents”) to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers, and enrollees, or to be published on the Exchange’s website for***

*the intention of communicating information to said persons must meet the following requirements:*

- (1) *The documents must be written in plain language.*
- (2) *The documents should use terms consistent with those set forth in the disclosure for group health plans and health insurance issuers of the summary of benefits and coverage and the uniform glossary under the Affordable Care Act published by the Departments of Health and Human Services, Labor and the Treasury.*
- (3) *The Exchange must provide for meaningful access to limited English proficient individuals.*
  - a. *Tag lines must be provided on all documents in no less than 15 different languages, informing individuals how to obtain copies of the notice in their language or otherwise obtain assistance in their language.*
  - b. *If there are a minimum of 500 persons or 5% of the persons in the service area of the Exchange who are limited English speaking and proficient only in another particular language, the Exchange shall be required to translate notices and other documents into those languages.*
  - c. *Once an LEP individual makes a request for materials in a non-English language, the Exchange should provide all subsequent notices or other documents to the individual in that language.*
- (4) *The Exchange must ensure effective communication for people with disabilities.*
- (5) *All documents must be submitted to HHS for review of readability and must be approved by HHS prior to use. HHS must also review and approve the Exchange's plan for accessibility, both regarding LEP persons and persons with disabilities. The Exchanges must also consult with stakeholder representatives, specifically consumers or persons who represent the interests of consumers, in regard to document language.*
  - (c) *Reevaluation of appropriateness and usability.* The Exchange must reevaluate the appropriateness and usability of *documents* on an annual basis. *Any changes to documents must be approved by HHS.*
  - (d) *HHS shall develop model templates and translations of such, addressing Exchange program components that will be uniform across the states.*

### **§ 155.260 -- Privacy and Security of Information**

The proposed regulations Federal Exchange guidance allows “responsible parties,” presumably including a Navigator/CAP, to file electronic applications on behalf of consumers and sets out a framework for privacy and security standards. The privacy framework laid out in the proposed regulation likely brings most state Exchanges (those that make eligibility determinations) under the purview of HIPAA.<sup>2</sup> This will reassure consumers, but at the same time, it will pose a

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<sup>2</sup> See HHS Discussion of Proposed Exchange Regulation, 76 Fed. Reg. 136, 41882, 4196 (July 15, 2011). Security standards will be dictated by HIPAA, which require covered entities to maintain reasonable and appropriate

challenge for the Consumer Assistance and Navigator programs assisting Exchange consumers because The HIPAA privacy rule provides meaningful privacy protections for consumers, but it also requires covered entities to obtain a written release before accessing protected health information. This requirement could present significant barrier to real time enrollment.<sup>3</sup>

Two solutions present themselves. First, the Exchange could consider the Navigator/CAP a “business entity” under HIPAA, enabling it to access Exchange records without a separate release.<sup>4</sup> Second, the Exchange could include a “check off” box on applications so that Navigator/CAP staff can be deemed “responsible parties” with consent to handle protected health information. We suggest adopting both of these solutions. The large civil penalty of \$25,000 against any person who knowingly or willfully discloses or inappropriately uses confidential information by the Exchange offers further privacy safeguards.<sup>5</sup>

We do not believe that the Navigator/CAP program falls under the Gramm-Leach-Bliley Act (GLBA), because program staff will not be selling insurance.<sup>6</sup> We support the lack of reference to GLBA as a relevant standard for state Exchanges, but suggest HHS be explicit and state its view as to the applicability of that particular law.<sup>7</sup>

We urge HHS to consider establishing criteria for the collection and retention of information when a consumer is a survivor or victim of domestic violence. Guidance can come from the state and local agencies that administer child support collection programs. Although helpful in addressing possible conflicts with HIPAA rules, the Fair Information Practices Principles do not discuss protecting information as an issue of safety for survivors of domestic violence.

### ***Subpart E - Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans***

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administrative, technical, and physical safeguards for protecting electronic information. Privacy standards, on the other hand, will be dictated by HIPAA only if a state’s exchange functions satisfy the definition for covered entities handling protected health information as defined in HIPAA regulation.

<sup>3</sup> Office for Civil Rights, U.S. Department of Health and Human Services, Summary of the HIPAA Privacy Rule, OCR Privacy Brief, available at:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>

<sup>4</sup> However, in Massachusetts, the state CAP is not considered a business entity, and must obtain a written release before accessing a consumer’s records in the state database. Personal communication with Brian Rosman, Health Care For All Massachusetts, April 21, 2011.

<sup>5</sup> ACA, *supra*, n. 3 at § 1411(g); *see also* Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).

<sup>6</sup> The GLBA statute requires financial institutions, including health insurance issuers, to follow specified standards to protect consumers’ personal information. NAIC Consumer Representatives comments on the draft NAIC white paper “The Comparative Roles of Navigators and Producers in an Exchange: What are the Issues?,” submitted March 18, 2011.

<sup>7</sup> HHS indicates that it will require compliance with both HIPAA (as discussed above) and the confidentiality and safeguarding requirements of Section 6103 of the Tax Code. Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 CFR pt. 155).

Section 155.400 establishes several functions of the Exchange for the Individual Market. Generally, a commitment to uniformity of timing, procedures and forms will simplify outreach and consumer education as the Individual Market is opened.

***§155.400 Enrollment of qualified individuals into QHPs***

*(b) Timing of Data Exchange*

Paragraph (b) establishes standards for the actions related to the recording, sharing and correction of data on individual applicants/enrollees. As referenced above, uniformity of this category of transaction is critical to ensuring consistent access to coverage and we commend HHS. The Agency specifically requests comment on whether or not the regulations should codify a specific frequency for enrollment transactions such as in real time or daily in the final rule. We recommend that the Exchanges be required to use the best technology available for these transactions to avoid a common situation from the public benefits sector in which innovations have been delayed or denied because of outdated computer systems.

**RECOMMENDATION:** We recommend that the Agency adopt a specific timeframe. With regards to whether the standard should be real time or daily, we would direct that the Exchange and Insurers to be required to utilize the best industry standard available and be required to update their practices as technology evolves on a timeframe set in regulation.

*(d) Reconcile Files*

In this section, HHS will require a monthly reconciliation of data between the Exchange and the QHPs. We were very pleased to see this requirement, as it will mitigate the practice of retro-terminations of coverage. This pervasive practice negatively impacts consumers when they lose coverage because of a reduction in employment hours or illness. The individual continues using their health coverage not fully understanding that their eligibility for that coverage may have ended. When an individual is disenrolled retroactively by an insurer, the individual will likely find him or herself liable for large medical bills, which is especially devastating for a household that is already struggling due to a reduction in income and/or serious illness.

***§155.405 Single Streamlined Application***

The benefits of requiring a uniform single streamlined form are clear and will facilitate education and accountability in the practices of the various Exchanges and with Insurers. We recommend that the criteria for readability and accessibility for notices addressed in Section 155.230(b) be required here. We must express some concern that only the National Association of Insurance Commissioners will be participating in the development of criteria for this single streamlined form and not the advocacy community that works specifically with low-literacy and disabled populations. This is particularly concerning since the proposed form will be used for those consumers who might be eligible for the advance payment of premium tax credits, cost-sharing reductions and Medicaid, CHIP and BHPs where available in addition to simple enrollment in the QHPs.

**RECOMMENDATION:** Require the participation of consumer advocates with experience in providing services to low-literacy and other vulnerable populations in the development of criteria for the enrollment form developed by individual Exchanges.

*(b) Alternative Application*

This provision states that HHS will approve this application and will identify or set the minimum information necessary for eligibility determinations for the subsidies codified in the Act. The Agency specifically requests comment on whether applicants will be required to answer questions that are not pertinent to the eligibility and enrollment process. This requirement reflects a commitment to protecting two specific groups of consumers. First, low-wage or unskilled workers that have periods of unemployment, underemployment or multiple employers may have difficulty securing documentation from multiple employers. Requests for excessive and unnecessary documentation would be a burden. Second, consumers with high medical usage due to illness or disability may be concerned if they are asked extensive questions about utilization. Unnecessary questions may have a chilling effect on vulnerable consumers either because of the burden of collecting unnecessary documentation or perceived “cherry picking” of consumers with fewer health needs. Furthermore, uniformity is critical in streamlining an expansion of access to health coverage and should be protected.

**RECOMMENDATION:** The application form and process should protect consumers from answering questions or collecting documentation that is not required for eligibility determination.

*(c) Filing the Single Streamlined Application.*

This provision enumerates who may file an application and how it may be filed. We welcome the codification of a variety of options for both issues. Under subsection (1), we request clarification of who is “Someone acting responsibly for the applicant.” Our experience in New York City is that with great frequency access to information is blocked or frustrated by requirements of provider specific release forms and/or participation of the consumer. Criteria should be developed to identify trusted community actors who can assist with applications.

**RECOMMENDATION:** The final rule should include criteria of how the Exchange will determine who is “Someone acting responsibly for the applicant.” In the section regarding the development of the simple streamlined application, an advocacy group not affiliated with the insurance industry should be identified to serve as a partner in the development of criteria to ensure a transparent and inclusive process.

*(c)(2) Provide the tools to allow for an applicant to file an application*

This subsection should remain unchanged in the final rule. The multiple methods by which an application may be submitted are well reasoned and reflect an understanding of the challenges faced by many segments of our diverse population. A paper application is essential to permit access for three specific groups of consumers. First, a number of consumers will not have access

to a web based application<sup>8</sup> or may not be able to make calls during standard business hours. Second, many disabled applicants may not be able to complete online or phone based applications because of their disabilities whether they have vision, auditory or comprehension type limitations. The assistance of a person is critical to their successful completion of an application. Third, low-literacy individuals may need the assistance of a person to complete an application successfully.

**RECOMMENDATION:** The regulation as written should be adopted in the final rule. A diverse set of forums to submit applications is appropriate given the diverse populations in need of coverage.

We urge HHS to consider establishing criteria for the collection and retention of information when a consumer is a survivor or victim of domestic violence. Guidance can come from the state and local agencies that administer child support collection programs. Although helpful in addressing possible conflicts with HIPAA rules, the Fair Information Practices Principles do not discuss protecting information as an issue of safety for survivors of domestic violence.

***§155.410 Initial and annual open enrollment periods.***

*(b) Initial Open Enrollment Period*

HHS seeks comment on the duration of the initial enrollment period specific in subsection (b) as October 1, 2013 to February 28, 2014. A longer initial enrollment period will allow the general public to learn about the process for enrollment, and will also allow the insurers, exchanges and individuals to adjust and make changes as needed during the enrollment period.

**RECOMMENDATION:** The proposed five month initial enrollment period is adequate.

*(c) Effective Coverage Dates for Initial Open Enrollment Period*

As we comment throughout, standards that require uniformity in enrollment procedures and access to coverage are the correct strategy. HHS seeks comment on whether a standard should be set as to the timing of effective dates for coverage as limited by the Affordable Care Act's requirements regarding access to the advance premium tax assistance. The two options for when coverage should begin discussed in the comments are fixed twice monthly dates or complete flexibility with coverage beginning immediately upon enrollment. Because individual responsibility for coverage is a key underlying principle of the Act, greater flexibility will support consumers' efforts to comply with this requirement. Furthermore, given the volatility of

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<sup>8</sup> The "digital divide" for people under age 60 is improving but low-wage workers (<\$30,000/year ) continue to lag 27% behind individuals with higher income in terms of access to computers and internet at work. Only 18% of these workers use the internet at work. There are racial differences as well. There is a 22 point gap between blacks and whites who have a computer at home (51% vs. 73%) .

"Survey shows widespread enthusiasm for high technology Americans love their computers and the internet; 'Digital Divide' still exists, but there is good news, too", NPR online, <<http://www.npr.org/programs/specials/poll/technology/>>, September 2011.

the labor market, complete flexibility will support consumers who find themselves without employer based coverage due to job loss or a reduction in hours.

**RECOMMENDATION:** The standard adopted should be complete flexibility with access to premium tax assistance becoming effective the first of the following month as per the requirements of the Act.

*(d) Notice of Annual Open Enrollment Period*

Comments are sought on the requirements for information pertaining to: (1) the date annual open enrollment begins and ends, (2) where individuals may obtain information about available QHPs, including website, call center, and through Navigator assistance, and (3) other relevant information. Requiring a specific time frame makes consumer outreach and education easier to plan, execute and monitor. Dictating specific information to be included and, in particular, including referrals to Navigator assistance will be of great value to more vulnerable consumers - individuals with disabilities, low-literacy and/or limited English skills. The notice should include some language regarding what are triggering events for a special enrollment period to protect a consumer that may not have understood that they can enroll mid-benefit year due to the triggering event. Requiring this information may help an individual consumer who is experiencing either a fiscal or health crisis and mistakenly thought they could not get coverage until the annual open enrollment period.

**RECOMMENDATION:** Whereas we withhold comment regarding whether 30 days is adequate, we do agree that a specific time frame should be set by regulation. The annual notice should include the proposed required information and specifically information on what events may trigger a special enrollment period.

*(e) Annual Open Enrollment Period.*

We welcome the Agency's interest in the advocacy community's opinion on setting the annual enrollment period. With regard to the specific periods proposed, we suggest that the period begin on October 15th, which is the same date as the annual open enrollment period for Medicare. However, we recommend that the period be extend beyond December 7th to include at least 60 days. This would facilitate individuals' ability to identify a new plan, confirm that their medical providers participate, learn about the plan's drug formulary, and determine what the premium will be with or without subsidies.

**RECOMMENDATION:** We recommend that the annual open enrollment period begin on October 15th and extend for at least 60 days.

*(f) Effective Date for Coverage After the Annual Open Enrollment Period*

HHS seeks comment on whether or not an Exchange should automatically enroll individuals who received advance payments of the premium tax credit and are then disenrolled from a QHP because the QHP is no longer offered if such individual does not make a new QHP selection. We agree that a consumer should not be disadvantaged when their plan ceases operations in their

area but do not understand why this situation would not trigger a special enrollment period as codified in §155.420 (d). An individual consumer who finds him/herself in this position should be allowed to choose their new coverage whenever they become aware of the change. Certainly, the Exchange should put them into a comparable plan, but allow them to change that coverage, including upgrading or downgrading their level as they feel most appropriate for the needs of the individual and their family.

**RECOMMENDATION:** The final rules should enumerate this situation as a triggering event for a special enrollment period as described in § 155.420(d). The Exchange should enroll the individual in comparable coverage pending their request for special enrollment period.

### ***§155.420 - Special Enrollment Periods***

Section 155.420 establishes special enrollment periods for individual exchanges. We support this provision, but recommend (1) that the timing for enrollment be adjusted in certain circumstances; (2) lengthening the special enrollment period to prevent gaps in coverage, (3) the addition of several other situations for special enrollment rights.

#### *(b) Effective Dates*

Once a qualified individual is determined eligible for a special enrollment period (SEP) the Exchange must ensure that the qualified individual's effective date of coverage is (1) on the first day of the following month for all QHP selections made by the 22nd of the previous month, and (2) on either the first day of the following month or the first day of the second following month for all QHP selections made between the 23rd and last day of a given month. An exception to this is provided in paragraph (c) whereas in the case of birth, adoption, or placement for adoption the date of coverage is immediate.

We agree that the proposed exceptions for birth, adoption, or placement for adoption are necessary. However, there may be additional circumstances which necessitate immediate, or in some cases retroactive coverage. Persons who lose coverage in the later part of the month because of sudden loss of a job that provided coverage and who do not have COBRA rights will be subject to more than a month-long coverage gap. Further, under the proposed rules, persons losing Medicaid or CHIP could be subject to enrollment delay. This is inconsistent with the statutory goals of seamless eligibility and enrollment, and could cause grave problems for low-income persons in the midst of medical treatment. Therefore, we strongly recommend that enrollees not be subject to a month-long enrollment delay even if they select a QHP in the later part of the month. At the very least, enrollees should be allowed the option of retroactive coverage. And HHS should design a fallback enrollment system to ensure that people losing Medicaid or CHIP coverage will not experience any gaps in coverage until their coverage under the Exchange becomes effective.

**RECOMMENDATIONS:** Require that every attempt be made to enroll all individuals on the first day of the month following selection, including those selecting a QHP after the 23rd of the month, and that the provision for effective coverage beginning on the first day of the second month be applicable only in cases of extreme administrative burden.

Require that any exceptions to enrollment on the first day of the following month not be applied to situations in which enrollees have one or more chronic conditions, have minor children requiring immediate care, or have otherwise emergent health needs.

Require that all enrollees be given the option of coverage retroactive to the date of loss of coverage, provided that they pay all premiums back to that date. Require a fallback system be put in place to prevent Medicaid and CHIP beneficiaries from experience any gap in coverage.

*(c ) Length of Special Enrollment*

Paragraph (c) provides that, unless specifically stated otherwise, a qualified individual or enrollee has 60 days from the date of a triggering event, as defined in paragraph (d), to select a qualified health plan. The Health Law Unit has advocated on behalf of numerous clients whose private insurance coverage has continued after their eligibility ceased, only to be faced with retroactive discontinuation of coverage sometimes several months later. The result is a lapse in private insurance coverage and/or significant medical bills as a result of their insurance provider failing to discontinue coverage at the appropriate time. In situations such as this, the SEP could expire before an individual is even made aware that a change to insurance status has taken place. To prevent lapses in coverage, we suggest an additional 30 days for all SEPs, which would provide an important cushion, especially for individuals with disabilities or other special needs who face particular challenges in making complex decisions about coverage.

**RECOMMENDATION:** Require that a qualified individual or enrollee has 90 days from the date of a triggering event, as defined in paragraph (d), to select a qualified health plan. Require that all enrollees be given the option of coverage retroactive to the date of loss of coverage, provided that they pay all premiums back to that date.

*(d) Special Enrollment Periods.*

This subsection describes the triggering events which allow qualified individuals and enrollees to enroll in or change from one QHP to another.

*(d)(1) Minimum Essential Coverage*

In the Act, minimal essential coverage is defined as Medicaid, Medicare Part A, CHIP, Tricare, VA Health, Peace corps health plans, eligible employer-sponsored plans, individual market plans, grandfathered pans, or other coverage such as a high risk pool – as long as the coverage does not consist only of essential benefits. We request that HHS clarify that a person losing any of those sources of coverage qualifies for special enrollment – that is, if an individual has two of the sources of coverage on the list, and lose one of them, the individual would still qualify for special enrollment. This clarification is necessary because some of the sources, such as Peace Corps plans, currently have lifetime limits, and grandfathered plans may not provide adequate coverage.

**RECOMMENDATION:** Require that loss of any one source of minimal essential coverage qualify an individual for special enrollment.

*(d)(4) Unintentional / Erroneous Enrollment / Non-enrollment*  
*(d)(5) Violation of contract by QHP*

These subsections address situations in which an enrollee is negatively impacted by actions of HHS, the Exchange, or a QHP. It is important that any SEPs triggered by this section be timed so as to hold harmless the individual impacted. It is unclear from subsection (4) when the effective date would be for a special enrollment period triggered by a finding that a qualified individual either enrolled or failed to enroll as a result of error, misrepresentation, or inaction of the Exchange or HHS. It is important that the SEPs in these situations are set up in such a way that an individual is never penalized for being unaware of any error or misrepresentation that was out of his or her control. In addition, subsection (5) allows for an SEP in a situation in which an enrollee “adequately demonstrates to the Exchange” that the QHP violated its contract. We request clarification on the manner in which an enrollee must demonstrate a contract violation to the Exchange. We are concerned that this provision places an undue burden on an enrollee who may not have the knowledge or resources to demonstrate a contract violation without access to additional information or support.

**RECOMMENDATION:** Require that, in situations of error, misrepresentation, or inaction on the part of the Exchange or HHS, SEPs begin at the time an impacted individual learns about the problem, or when the enrollment goes into effect, whichever is later. Require that in situations in which the QHP violates a provision of the contract, the SEP begins after the individual has learned about the violation or when the violation or the impact of the violation occurs, whichever is later.

*(d)(6) Premium Tax Credit/Employer-sponsored*

Subsection (d)(6) provides that an enrollee may have access to an SEP prior to the end of his or her coverage of an employer-sponsored plan if the individual’s “existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer’s upcoming plan year.”

**RECOMMENDATION:** Require that employee have the option of starting the SEP either when he/she terminates coverage provided by the employer-sponsored plan, or at the date he/she learns of the change in the employer-sponsored coverage. The first option will allow employees more time to enroll in a plan which may be necessary if they are experiencing changes in work and income. The second option would allow employees to more quickly obtain cheaper coverage in times of financial hardship.

*(d)(9) Exceptional Circumstances.*

Paragraph (d)(9) provides that a qualified individual or enrollee may be eligible for a 60 day SEP if he/she meets other “exceptional circumstances as the Exchange or HHS may provide.”

We support the language in the proposed regulations which define exceptional circumstances as “a variety of situations, including natural disasters such as hurricane or floods...circumstances that would impede an individual’s ability to enroll on a timely basis, through no fault of his or her own.”

We also agree with the language in §155.430 (c)(3), which establishes a requirement that QHP issuers provide “reasonable accommodations” with regard to the termination of coverage for individuals with mental or cognitive conditions. At the Legal Aid Society, we often assist clients with complex mental and cognitive conditions to navigate the bureaucracy of the state Medicaid system. Though the New York State Medicaid system does not have strict or special enrollment periods, many of our clients with mental and cognitive conditions are unable to submit even annual recertification packets, or monthly spend-down documents in a timely manner, making these deadlines in effect a barrier to care.

**RECOMMENDATION:** Require QHP issuers to provide “reasonable accommodations with regard to the special enrollment period for individuals with mental or cognitive conditions, including mental and substance abuse disorders, Alzheimer’s disease, and developmental disabilities.

*(f) Limits on Special Enrollment Periods*

This subsection prohibits special enrollees from changing tiers of coverage during the SEP, unless they have become newly eligible for a premium tax credit or there was a change in their cost-sharing subsidy level. Although we acknowledge the concern about adverse selection raised by HHS, we believe that the need for flexibility outweighs these concerns. In addition to allowing pregnant women in catastrophic plans to change tiers, there are numerous other circumstances, including the addition of a dependent to a family, which would make it necessary to change levels of coverage during an SEP in order for an enrollee to access an affordable and appropriate plan. That an SEP is only available in very limited circumstances should allay concerns about adverse selection.

**RECOMMENDATION:** We recommend that this prohibition on changing tiers of coverage during SEPs be eliminated. At the very least, there should be exceptions to this provision in cases involving pregnancy and changes to family composition.

***§155.430 Termination of Coverage***

*(a) General Requirements*

While we support the general requirement that “the Exchange must determine the form and manner in which coverage in a QHP may be terminated, we recommend that HHS make clear the manner in which consumers are permitted to notify the Exchange of their intent to terminate coverage, and eliminate the “reasonable” standard for setting a termination date.

*(b) Termination Events*

We agree that enrollees should be permitted to terminate coverage as proposed in paragraph (b)(1). We are very supportive of the requirement that Exchanges monitor procedures for termination and submit data to HHS on a monthly basis. However, in our practice we encounter enrollees whose coverage has continued despite their attempt to terminate it often resulting in the assessment of penalties. Therefore, we think it critical that HHS require Exchanges to monitor not just the termination, but the request for termination, so that data will be available on QHP compliance with consumer's requests.

We encourage HHS to allow enrollees to request termination orally both in person and by telephone, and in writing. Where termination is requested orally, we propose that enrollees be provided with a method of tracking the actual request including the date the enrollee requests termination of coverage. This can be accomplished by providing a case or tracking number at the time the oral request is made. Finally we suggest that HHS provide the name, telephone, address and fax number of the individual(s) who are authorized to accept requests for termination of coverage.

Although we agree with defining the specific events as set forth in paragraph (b)(2) that will trigger termination of coverage by the QHP, we encourage HHS to define the notice requirements that must be provided before coverage may be terminated and the rights afforded if adequate notice is not provided. Section 155.430 is silent on the matter of notice required at termination. Section 156.270, which addresses the QHP Issuer Standards for termination of coverage, does not make up for the lack of specificity in §155.430 and only requires the QHP issuer to provide notice of the effective date of termination. Although the QHP issuer is required to provide notice to the enrollee of non payment of premiums under paragraph (e), notice of termination at the end of the grace period is not required.

We recommend that that HHS define what constitutes "appropriate" notice by adopting our comments with regard to the General Standards for Exchange Notices, including our recommendations with regard to accessibility and readability, and specifying their applicability to termination notices. Under these standards, the notices would need to identify those members of the household whose benefits will be affected by termination, the specific reason for the termination, appeal rights and persons to contact. A second notice would be required if the enrollee does not respond to the first notice of termination.

**RECOMMENDATION:** To allow enrollees to request termination orally and in writing, to provide specific contact information for submitting termination requests, and where request is oral, to provide case number or tracking number at time oral request is made to allow confirmation of request.

#### *(d) Effective Dates of Termination of Coverage*

Subdivision 155.430(d)(1) states that where termination is the result of the enrollee's request, the last date of coverage is the termination date specified by the enrollee if the Exchange and the QHP had a "reasonable amount of time from the date on which the enrollee provides notice to terminate" coverage, otherwise the last date of coverage is the first day after such reasonable amount of time has passed. Although we applaud HHS for allowing the enrollee to define the

exact date of termination, we think that basing the date of termination on a “reasonable” standard leaves room for confusion, and are concerned that the lack of specificity may result in gaps in coverage or duplicate coverage. Instead, we suggest a standard similar to that stated in paragraph (4) be adopted:

**RECOMMENDATION:** We recommend amending §155.430(d) to include the following language:

(1) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of coverage is: ~~the termination date specified by the enrollee, if the Exchange and QHP have a reasonable amount of time from the date on which the enrollee provides notice to terminate his or her coverage. If the Exchange or the QHP do not have a reasonable amount of time from the date on which the enrollee provides notice to terminate his or her coverage, the last day of coverage is the first day after such reasonable amount of time has passed.~~

*i. The fourteenth day of the month if the employee’s notice to the Exchange or QHP is sent by the enrollee no later than the fourteenth day of the previous month;*

*ii. The last day of the month if the notice to the Exchange or QHP is sent by the enrollee no later than the last day of the previous month.*

## **Subpart H - Exchange Functions: Small Business Health Options Program (SHOP)**

### ***§ 155.440 Standards for the Establishment of a SHOP***

Section 1311(b)(1)(B) of the Affordable Care Act directs each state that chooses to operate an Exchange to establish options for small businesses through a Small Business Health Options Program (SHOP). This program will enable small employers to offer affordable health plans to their employees and provide small businesses the choices and purchasing power typically enjoyed by large businesses. In addition, certain small employers will be eligible to receive a small business tax credit. The program is strictly voluntary for small employers,

Our comments refer to the SHOP in general, and not to specific sections of the regulations. The Legal Aid Society’s Community Development Project provides assistance to low-income small businesses in New York City. These small businesses, sometimes known as microenterprises, typically employ fewer than five workers and have limited capital. The owners of these businesses are often low-income people themselves, with incomes in the range of two to four times the federal poverty guidelines. In most cases, they will be unable to afford the cost of providing health insurance to their employees. Unfortunately, it seems unlikely, for the reasons stated below, that these microenterprises will benefit from the SHOP.

Many low-income small business owners will not benefit from the small business health care tax credit because their limited earnings leave them without a significant tax burden. Therefore, they will have no need to avail themselves of the tax credits available to businesses that make health insurance available to their employees. Furthermore, low-income small businesses are often family-owned, and the owners and their family members are also employees of the business.

However, the premiums paid to cover owner-employees or family member-employees are not calculated when determining the amount of the health care tax credit, which creates an additional disincentive for the low-income small business employer to participate in the program. In sum, since, any additional cost is likely to be unaffordable to a low-income small business, and these employers will not benefit from the tax credit incentive, it is safe to assume that most of these entities will decline to participate in this voluntary program.

Although many low-income small businesses will decline to participate in a SHOP, the majority of the owners of these businesses and their employees will be eligible to purchase individual insurance through an Exchange and to receive the premium tax credit, which is available to individuals and families with incomes between 100% of 400% of the federal poverty guidelines.

Nevertheless, it is important that small businesses that choose not to provide health insurance coverage for their employees through a SHOP be encouraged to advise their employees that they may be eligible to purchase private coverage through an Exchange, and that they may be eligible for advance payments of the premium tax credit, Medicaid and CHIP.

Reaching these eligible Americans, however, will be a challenge because many of them are immigrants with incomplete English language skills and limited internet access. Common means of communication, such as e-mail or advertisements, will be less effective in reaching the low-income and immigrant small business community. Therefore, other means of communication and outreach should be employed, and local social services organizations, community groups, and houses of worship should be enlisted to provide information regarding coverage and encouragement regarding enrollment.

**RECOMMENDATION:** We recommend that the Exchanges use business groups to reach the owners and employees who will not be covered through a small business health exchange. In particular, immigrants are often drawn to certain businesses, including beauty salons, groceries and restaurants. Existing immigrant business associations provide information and advocacy to many of these businesses and are an excellent means to inform this population about the availability of individual coverage and the premium tax credit. Immigrant education and advocacy groups will also be an important source of information about affordable health insurance coverage.

### ***Conclusion***

In sum, while we are encouraged that HHS made several strong statements in the Proposed Rule that will benefit Exchange participants, we feel that some parts of the rule must be amended or clarified. If you have any questions about these comments, please contact or Trilby de Jung at (202) 289-7661 or Liliana Vaamonde at (212) 577-3928. Thank you for your consideration of our comments.

Sincerely,  
/S/  
Steven Banks  
Attorney-in-Chief  
The Legal Aid Society

Sincerely,  
/S/  
Trilby deYoung  
Senior Attorney  
Empire Justice Center