Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

Community Catalyst

March 15, 2013

COMMENTS to the Department of Health and Human Services, Centers for Medicare & Medicaid Services

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

Community Catalyst respectfully submits the following comments to the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) in response to the proposed guidance in the Issuer Letter on Federally-facilitated and State Partnership Exchanges released March 1 2013.

Community Catalyst is a national non-profit advocacy organization dedicated to securing access to quality, affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state, and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

We greatly appreciate the letter to issuers and the opportunity to provide comments on this guidance. The letter gives issuers, states and consumers a clearer understanding of how Exchanges will be operationalized by January 2014.

However, there are a few areas of concern for consumers on compliance and enforcement of rules, network adequacy, enrollment in insurance, and language access standards. Below we outline these concerns and offer recommendations to strengthen the guidance.

Chapter 1, Section 1. Network Adequacy and Inclusion of Essential Community Providers

i. Network Adequacy

In this section, CMS addresses how it will review qualified health plans (QHPs) for compliance with network adequacy and essential community provider (ECP) standards.

Many states currently do not have network adequacy standards or have them for only one segment of the market. This means that CMS will rely on an issuer's interpretation of network adequacy. This is problematic because it is often in the best interest of issuers to keep networks restricted. For consumers, this could create barriers to needed care.

It is also worth highlighting that the final rule for Essential Health Benefits (EHB) does not count out-of-pocket expenses toward out-of-network providers. The reasoning behind this (as stated in the preamble) was that future network adequacy standards would properly address consumers' provider access needs, making out-of-network access less relevant. Therefore, a strong standard for network adequacy is necessary for consumers to access appropriate and necessary care and to maintain care continuity. **We recommend that CCIIO develop a robust network standard.** Robust measures for network adequacy could include collecting data on provider capacity and average wait times; requiring this data to be posted in a prominent place on the QHP's website and updated periodically. We encourage CMS to monitor this data for accuracy.

In a similar vein, it is also unclear to consumers how and where they will file complaints about network access. **We recommend a single point of contact for consumer complaints regardless of issuer or plan type.** If states do not have the capacity to collect complaints, we suggest there be a contact at CMS. Additionally, we recommend that the consumer complaint process be fully transparent and include a clear timeline for response.

ii. Essential Community Providers

We strongly support the requirement that QHPs maintain a sufficient number of ECPs that serve predominantly low income, medically underserved individuals in their care network at all times. This is an important step to help ensure that the needs of low-income populations are met and QHPs are able to fully comply with National Standards on Culturally and Linguistically Appropriate Services (CLAS)[1].

We strongly urge CMS to increase the minimum expectation of 10 percent of available ECPs to be contracted by QHPs. This standard is much too small to ensure reasonable and timely access to a broad range of providers for low-income, medically underserved individuals in the service area, and will in fact prevent vulnerable individuals from getting adequate care. **We recommend that CMS raise the minimum standard to at least 50 percent.** The Connecticut Health Insurance Exchange requires QHPs to contract with at least 75 percent of the ECPs in any county and at least 90 percent of the federally qualified health centers or "look-alike" health centers in the state[2]. Therefore QHPs can reasonably meet at a minimum the 50 percent standard.

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[1] US Department of Health, Office of Minority Health: National Standards on Culturally and Linguistically Appropriate Services (CLAS). http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=15

[2] Connecticut Health Insurance Exchange: Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges. http://www.ct.gov/hix/lib/hix/Connecticut_QHP_Solicitation_(Final_12132012).pdf

We also strongly support a comprehensive list of essential community providers that include:

- Federally qualified health centers and family planning projects receiving grant funds under Title X of the Public Health Service Act
- Ryan White Care Act providers furnishing HIV/AIDS services, state AIDS drug purchasing assistance programs (ADAP)
- Tribal and urban Indian organization providers
- Hospitals including DSH and DSH-eligible hospitals, children's hospitals, rural referral centers and sole community hospitals
- ECP providers such as community mental health centers and other mental health and substance use disorder organizations that are licensed or certified by the state as providers, STD clinics, TB clinics, black lung clinics, hemophilia diagnostic treatment centers, etc.

Chapter 1, Section 4: Benefit Design Review

ii. Supporting Informed Consumer Choice

While CMS has clearly articulated that it will accept all qualified QHP issuers initially, we are pleased that CMS will review QHPs to ensure meaningful difference between plans. **We support this work and encourage CMS to move toward greater standardization to facilitate apples-to-apples comparisons through the Exchange.** This is also critical as a way to prevent benefit design from becoming a way of steering certain members to plans.

Chapter 3, Section 1. Account Management

The issuer letter describes in greater detail how CMS will monitor QHP performance during the year. In FFEs and Partnership Exchanges, issuers will rely on a federal Account Manager as their primary point of contact regarding Exchange questions. While this creates an important communication avenue between issuers and CCIIO, it is unclear how and if consumers have access to the Account Manager to communicate issues with QHPs.

We recommend that consumer groups have access to federal Account Managers to provide a direct line to CMS to provide overall consumer input. It is important to note that in FFE states, some state officials either prevented or refused to establish a State-Based Exchange, in most cases, due to anti-ACA sentiments. Therefore, state environments may not be conducive to receiving consumer input about FFEs. In order to ensure the success of Exchanges, we recommend that CMS make sure that consumer advocacy organizations and entities that provide consumer assistance have a voice in shaping QHPs in FFEs.

Chapter 3, Section 2. QHP Issuer Compliance and Oversight

In this section, CMS describes its risk-based approach to compliance and oversight, relying heavily on states for oversight of issuers. While state regulators are most

knowledgeable about their own insurance markets, CMS's passive approach to compliance is problematic. States may lack both capacity and authority to properly enforce QHP compliance. **We encourage CMS to perform compliance reviews at random and to step in when appropriate and necessary, instead of just when there are complaints.** While aggregating complaints over time is a good indicator of a problem, consumer complaints should also be rated for urgency so that consumers are not put at risk.

Additionally, as a part of a structured process to determine compliance, **we encourage HHS to use existing networks of consumer advocacy groups as partners in ongoing evaluation.** Once people begin enrolling in QHPs, state consumer assistance programs will become well-versed in how well plans meet the needs of consumers. Navigators will play a similarly important role in identifying gaps in coverage, as well as where QHPs serve consumers well. By working with consumer assistance groups and nonprofits that serve vulnerable populations, CMS will gain a more expansive understanding of QHPs.

Chapter 3, Section 3. QHP Marketing

CMS has indicated that they do not plan to review marketing materials and will rely on states to perform this task. Research by the National Academy of Social Insurance (NASI) and Georgetown's Center on Health Insurance Reforms (CHIR) found that Departments of Insurance typically do not review these materials.[3] **We recommend that CMS take a more active approach in reviewing marketing materials to protect consumers from predatory practices.** Especially if issuers are allowed to directly enroll individuals, it is critical that there is oversight of their marketing materials and tactics.

Chapter 5, Section 1. Overview of the Enrollment Process for Qualified Individuals

We appreciate that CMS has outlined the process for enrollment in a QHP. However, many consumers will find this process complex, and we know that people will seek one-on-one assistance for their questions.[4] **We urge CMS to require issuers and states to notify individuals about Navigators available in their area to provide unbiased help about their QHP options as part of the enrollment process.**

Chapter 5, Section 9. Direct Enrollment with the QHP Issuer

We urge CMS to reconsider the guidance that allows a consumer to be enrolled in coverage "through the Exchange" directly by an issuer. This policy is in direct conflict with previous CMS guidance aimed to prevent brokers from steering people toward a particular health plan within the Exchange for financial reward. But issuers have

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[3] Sabrina Corlette, JoAnn Volk, Kevin Lucia. Plan Management: Issues for State, Partnership and Federally Facilitated Health Insurance Exchanges. National Academy of Social Insurance. May 2012. http://www.nasi.org/sites/default/files/research/Plan_Management_Issues_for_Exchanges.pdf

[4] Lake Research Partners. Preparing for 2014. Robert Wood Johnson Foundation. State Health Reform Assistance Network. June 2012. http://www.statenetwork.org/resource/preparing-for-2014-findings-from-research-with-lower-income-adults-in-three-states/

even greater conflicts of interest in enrollment than brokers, and should not be able to directly enroll consumers in their plans through the Exchange. By giving insurers direct access to the Exchange website and enrollment tools, this policy also undermines the goal of the Exchange – to provide consumers with unbiased information from which to choose a health plan that best meets their needs. When coupled with the lack of federal oversight on marketing materials for plans, this policy could result in predatory practices and steer people toward specific health plans based on their risk factors.

If prohibiting issuers from enrolling people directly through the Exchange is not possible, **issuers should be required to comply with a number of additional standards to ensure consumer protections**, including providing, both verbally and in writing:

- An explanation of the Exchange and how the issuer is separate and distinct from the Exchange,
- That other health plans are available, and these plans may be of lower cost and higher quality to the individual
- A list of other available health plans
- Disclosure of conflicts of interest
- The option to go to the Exchange to compare different plans for cost and quality
- Information about how to access available Navigators in the area that provide unbiased consumer assistance.

We encourage CMS to develop standardized materials and templates for issuers to convey this information.

Chapter 5, Section 10. Agents and Brokers

In states that permit agents and brokers to help enroll people through an Exchange, we recommend that HHS clarify the oversight of brokers between the state and federal levels. We also **recommend that HHS require all agents and brokers to disclose to the Exchange and applicants any relationships the agent or broker or sponsoring agency has with QHPs or insurance affordability programs**, as well as any other potential conflicts of interest. We recommend that CMS develop standards for the types of relationships and potential conflicts of interest that must be disclosed, as well as the format for disclosing such relationships or conflicts to applicants (i.e. both verbally and written in plain language). This information will be important not only to consumers, but also to the Exchange in identifying patterns of enrollment that suggest steering to a plan.

We also recommend that the guidance be amended to require agents and brokers to be trained in public programs and how to provide culturally and linguistically appropriate services, especially to vulnerable low-income families. This training should include how to assist limited-English proficient individuals and immigrant families, especially those with mixed immigration status.

Chapter 6, Section 1. Call Center and Website.

The guidance provides some information about what will be provided by the FFE call center and website operated by HHS. Providing services in only English and Spanish will

not be adequate to serve the diverse needs of people who will be seeking coverage through the Exchange. We recommend that CMS require call centers operated by issuers and the HHS call center offer oral interpretation, such as through telephonic interpreter services, in the top 150 languages.

Chapter 6, Section 4. Complaints Tracking and Resolution

We applaud CMS for planning for ongoing oversight and evaluation of QHP issuers through tracking complaints. Because some states may not have the capacity or willingness to compile and address consumer complaints, **we recommend also including an option for individuals to directly file complaints with CMS**. This process could be accomplished through existing networks of consumer advocacy groups as partners. State consumer assistance programs will become good resources for data about how QHPs meet the needs of consumers. Navigators will play a similarly important role in identifying gaps in benefits and care. By working with consumer assistance groups and nonprofits that serve vulnerable populations, HHS will gain a more expansive understanding of complaints and ways to strengthen the health system.

Chapter 6, Section 6. Meaningful Access

Language barriers have been found to predict lack of access to health services. With one out of four expected insurance Exchange applicants speaking a language other than English at home many individuals are at a high risk of being left out of the benefits of health reform. Strong requirements on, and enforcement of, language access services in all Exchange operations would help improve access to insurance.

Exchanges have the responsibility to provide appropriate language access services, including translation of documents (i.e. descriptions of health plan choices, grievance procedures, applications and notices) and interpreters to enrollees under the nondiscrimination protection of the ACA as well as Title VI of the Civil Rights Act of 1964 prohibiting discrimination on the basis of race, color or national origin, gender and disability. We recommend requiring free translation and oral interpretation of materials issued by QHPs to enrollees.

At the minimum, the standards we recommend include:

- **Translate forms and notices used or produced by QHPs when a language group is 5 percent of plan enrollees or 500 people**. We draw the 5 percent standard from the Department of Justice (DOJ) and HHS' Limited English Proficiency Guidance, and the 500 person standard from the interim final rule established by the DOJ, HHS and the Department of Treasury governing appeals documents in non-Medicare health plans. All forms and notices should be written in plain language and provided in a manner that ensures meaningful access to limited English proficient individuals.
- **Include taglines on non-vital notices indicating the availability of translated material or oral interpretation in the top 15 non-English languages in the**

state. This is the current standard used by Medicare and by the Social Security Administration.

- **Provide free access to oral interpreters** or bilingual staff on request, regardless of whether thresholds for written translation are met.
- **Translate the content of QHP issuer websites** with content in English into Spanish and include taglines in the top 15 non-English languages in the state, indicating the availability of free language assistance services through a QHP issuer's call center.

Thank you for the opportunity to provide comments on this proposed guidance, and for continuing to make consumers a priority in your important work implementing the Affordable Care Act. If you have any questions regarding our comments, please contact Christine Barber (cbarber@communitycatalyst.org).

Respectfully submitted,

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