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

Re: CMS-9949-P - Proposed rules regarding the Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and beyond

Submitted by Community Catalyst
April 21, 2014

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 regulations released March 14, 2014 regarding various requirements applicable to health insurance issuers, Exchanges, Navigators, and health plans under the Patient Protection and Affordable Care Act (ACA).

Community Catalyst is a national non-profit advocacy organization dedicated 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 appreciate the opportunity to provide comments on this regulation. We have focused our comments on regulating limited benefit plans, standards for Navigators and other assisters, special enrollment periods, the affordability exemption, and Exchange plan quality measures.

§ 148.220 Excepted Benefits

We support CMS's attempt to regulate fixed-dollar indemnity coverage of health care services, often referred to as "mini-med" policies. One purpose of the Affordable Care Act was to eliminate mini-med products that have in the past created the illusion of major medical coverage, but in fact offered their enrollees little protection for health care expenses. While there may be a continuing role for fixed-dollar indemnity products as income replacement insurance and supplementing comprehensive medical coverage, issuers must not be allowed to mislead consumers into believing that this fixed-dollar coverage is adequate coverage or a substitute for comprehensive insurance.

Issuers should be required to clearly inform consumers that any fixed-dollar coverage does not meet the individual responsibility requirement and is only supplemental coverage to their minimal essential coverage.

We support the restrictions on fixed-dollar coverage found in the proposed rule, particularly the requirements that coverage can only be sold to individuals who otherwise have minimum essential coverage and that consumers be warned that fixed-dollar

indemnity coverage is not itself minimum essential coverage or major medical coverage. Consumers should not only be given the warning included in the regulation, but should have to separately initial that they understand it. Issuers should be required to see and keep on file actual proof of minimum essential coverage, such as a copy of an insurance card or policy, before issuing a fixed-dollar coverage policy. This imposes a minimal burden for the issuer, but is an important protection from the consumer. We would vigorously oppose any effort to weaken these basic consumer protections.

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

To the extent there are civil money penalties (CMPs) on Navigators, non-Navigator assistance personnel, and certified application counselors (CACs), we agree that CMS should have enforcement authority to ensure that consumers interacting with the Exchange receive high-quality assistance and robust consumer protection.

In particular, we support CMS's intention to work collaboratively with consumer assistance entities and personnel to prevent noncompliance issues and address any that may arise before they might rise to a level where a CMP would be imposed. We further support CMS's decision to make the CMP amount, and the opportunity to enter into a corrective action plan, vary based on several factors such as the consumer assistance entity's previous or ongoing record of compliance; the gravity and frequency of the violation; the financial harm incurred by the consumer; and the culpability of the consumer assistance entity. Lastly, we support the decision to make these enforcement provisions align with PHS Act §2723(b)(2)(C)(iii)(II), under which no CMP may be assessed for violations due to reasonable cause and not due to willful neglect, if the violation is corrected during the 30-day period beginning of the first day the entity knew, or exercising reasonable diligence would have known, that such failure to comply with program standards existed.

However, we are concerned that some consumer assistance entities may be discouraged from participating in the Navigator, assister, or CAC programs due to the possibility of having CMPs imposed against them. Due to this concern, **we recommend that CMS first require any consumer assistance entity that is alleged to have violated program standards to enter into a corrective action plan before a CMP could be issued.** We further recommend that CMS only impose a CMP if a consumer assistance entity has either failed to create or follow through with a corrective action after being requested to do so by CMS. We believe that requiring a corrective action plan as a necessary first step before imposing a CMP would maintain robust consumer protection and strong CMS enforcement authority within the Navigator and non-Navigator assistance programs without discouraging program participation. Finally, assisters should not be responsible for errors made in the technical or administrative process of applying for health benefits.

§155.210(c)(1)(iii)(A)-(F) Navigator Program Standards

We strongly support the regulations specifying a non-exhaustive list of non-federal laws that apply to Navigators, assisters, or CACs that CMS would consider as preventing the application

of the ACA. **We recommend that the list remain non-exhaustive in recognition of the fact that other types of laws not mentioned in the proposed regulations may nevertheless prevent the application of the ACA.**

We agree that non-Federal laws which require Navigators and other enrollment assisters to refer consumers to insurance agents or brokers would prevent the application of the ACA. We agree with CMS's finding that insurance agents and brokers *are not* required to provide impartial information and advice, while in contrast Navigators and other enrollment assisters *are* required to provide impartial and accurate information to consumers. Therefore, if Navigators are required by a state law to refer consumers to third parties that do not have a duty to provide consumers with impartial and accurate information, then they cannot uphold their duty to ensure that consumers are receiving information in this way.

We also support the regulation that considers non-federal laws that prevent enrollment assisters from providing services to all persons as preventing the application of the ACA. An example of this is Georgia HB 198, which prohibits Navigators from assisting individuals who are currently insured. We support CMS's interpretation of the requirement that enrollment assisters provide information and services fairly and impartially as a requirement that they provide their services to all consumers seeking assistance. We further support the view that Navigators and other enrollment assisters should have the ability to help any individual who presents him or herself for assistance. Since the ACA authorizes Navigators to assist any consumer who desires assistance, the Georgia law and others meeting this regulation's definition prevent the application of the ACA.

We agree with CMS that non-federal laws that prevent enrollment assisters from discussing the terms of coverage of a plan or providing advice about a particular plan prevents the application of the ACA. For example, laws in Georgia, Missouri, Ohio and Tennessee prohibit Navigators from providing advice about health plans. The ACA explicitly requires all types of enrollment assisters to "facilitate selection of a QHP," which necessarily requires them to provide comprehensive information about the substantive benefits and features of a plan. Therefore, these types of laws prevent enrollment assisters from fulfilling their duty to facilitate a consumer's selection of a health plan.

We also agree that Navigators should not be required to become agents or brokers or carry errors and omissions coverage. For example, laws in Iowa, Utah and Wisconsin require Navigators to purchase errors and omissions insurance or other types of coverage to protect against claims of wrongdoing. We support CMS's finding that because all Exchanges are required to have two types of entities serve as Navigators, one of which is a community and consumer-focused nonprofit, requiring all Navigators to be a licensed agent or broker or carry errors and omissions insurance would mean that all Navigators would fall under only one type of entity. We support the view that Navigators should be distinguished from insurance agents or brokers, and that requiring Navigators to carry insurance that only licensed agents or brokers are typically required to carry blurs this distinction. **We also recommend that CMS prohibit non-federal laws that require Navigators to carry surety bonds to preform their duties.**

We support the view that laws that prohibit consumer assistance entities from receiving any consideration from an insurer, even if not in connection with the enrollment of individuals into a qualified health plan, prevents the application of the ACA. We agree with CMS that these laws go beyond the federal conflict of interest policy which only prohibits enrollment assisters from receiving financial consideration in connection with the enrollment of individuals into a qualified health plan. In addition, these laws have prohibited certain entities from serving as Navigators, such as hospitals and community health care clinics, which would otherwise be eligible under federal law. For example, one hospital in Ohio decided to return its Navigator grant money after the state passed a law that prohibited any entity that negotiated with insurers from serving as a Navigator. Lastly, we agree with CMS's blanket prohibition of any non-federal law that would have the effect of preventing the application of any federal standards applicable to Exchanges, Navigators, non-Navigator assistance personnel and CACs.

§155.285 Bases and process for imposing civil penalties for provision of false or fraudulent information to an Exchange or improper use or disclosure of information

We agree that CMS should have authority to impose civil money penalties (CMPs) on any person or entity that gains access to personally identifiable information through an Exchange and 1) provides false or fraudulent information, or 2) improperly uses or discloses information. In particular, we support that CMS may take into account several factors in determining whether to impose a penalty, such as 1) the number and severity of the violations; 2) the length of time of the violation; 3) the number of persons affected; 4) the nature and level of harm caused by the conduct; 4) the person's conduct history within the Exchange. We further support CMS's decision to not impose a penalty if CMS determines that there was a reasonable cause for the failure to provide correct information.

However, we are concerned that some eligible persons may be discouraged from participating in the Navigator, assister, or certified application counselor programs due to the possibility of having CMPs imposed against them for providing false information or improperly using or disclosing information. Due to this concern, **we recommend that CMS first require any consumer assistance entity that is alleged to have provided false information or improperly used or disclosed information to enter into a corrective action plan before a CMP could be issued. We further recommend that CMS only impose a CMP if a consumer assistance entity has either failed to create or follow through with a corrective action after being requested to do so by CMS.** We believe that requiring a corrective action plan as a necessary first step before imposing a CMP would maintain robust consumer protection and strong CMS enforcement authority within the Navigator and non-Navigator assistance programs without discouraging program participation.

§ 155.420 Special Enrollment Periods

We support the proposed amendments to this section, which help to provide access to coverage outside of open enrollment periods in certain situations. In particular, we support the clarification that people who know they will lose minimum essential coverage within 60 days have the ability to establish Marketplace coverage ahead of time to minimize or avoid gaps during the transition, and that this is not limited to only people losing employer-sponsored coverage. **We strongly**

support ensuring that women losing coverage of Medicaid pregnancy-related services have the option to enroll in a Marketplace plan.

Along with the changes that have been proposed, **we urge CMS to include an additional provision to ensure there is a special enrollment period available to certain people who experience a change in life circumstances that makes them newly eligible for subsidies.** Currently, the rules permit only people already enrolled in a qualified health plan (QHP) or those losing eligible employer-sponsored coverage to qualify for a special enrollment period due to becoming newly eligible for advance premium tax credits (APTCs). However, between April 1 and November 15, 2014, when the 2015 open enrollment period begins, a substantial number of people who did not apply for Marketplace coverage before March 31, or who applied and did not enroll because they were denied subsidies and couldn't afford coverage, will experience changes in circumstances that affect their ability to obtain and afford health insurance. Without changes to the regulations, some of these people will be unable to enroll in coverage until November 15, 2014, and their earliest coverage effective date will be January 1, 2015.

We recommend revising 45 CFR §155.420(d)(6) by inserting a new subsection (iii) and making the current (iii) subsection (iv). The new subsection would read as follows:
(iii) A qualified individual or his or her dependent has a change in income or tax household composition or tax household size resulting in a determination that he or she is newly eligible for advance payments of the premium tax credit;

Changing the policy as we recommend above would allow people in the following situations to qualify for SEPs:

- *People who would have been eligible for Medicaid but live in states that did not take the Medicaid expansion **and** who become newly eligible during the year for premium tax credits because of an increase in income or a change in household composition or size.* Many people in the Medicaid coverage gap will likely remain uninsured in 2014. However, some people may experience an increase in income or a change in household size during the year that would make them eligible for premium tax credits. Under current rules, they would *not* qualify for a SEP unless they had applied for coverage and been denied Medicaid, received an exemption from the shared responsibility payment based on being in the Medicaid coverage gap, and subsequently lost the exemption because of their increased income.

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

Even then, only people whose income goes above 138 percent of the poverty line would actually lose the exemption. Those whose income ends up between 100 and 138 percent of the poverty

line would still qualify for an exemption and could not qualify for a SEP, even though they are newly eligible for premium tax credits.

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

- *People who have access to employer-sponsored coverage but do not enroll in it because, while it may meet the ACA's technical definition of affordability, it is not affordable in practical terms.* These are people who have an offer of employer-based coverage but have not enrolled in the coverage, because they find it too expensive. If such a person loses his or her job and thus loses access to the job-based plan, the individual and their family could become eligible for Marketplace subsidies. But the individual may not be able to access a Marketplace plan outside of open enrollment, because he or she would not qualify for a SEP related to loss of employer coverage since the individual hadn't enrolled in the employer plan.

- *Victims of domestic abuse that occurs after May 31, 2014.* Guidance issued by the IRS on March 26 allows married survivors of domestic abuse to qualify for premium tax credits in 2014 even though they file their taxes separately from their spouses. The guidance on complex cases gives people in this situation until May 31 to apply and enroll in coverage. However, a person who experiences domestic abuse after May 31 would not qualify for a SEP even if they separated from their spouse and knew they would be filing their taxes separately.

§ 155.625 Options for conducting eligibility determinations for exemptions.

The preamble related to this section discusses potential methodologies for adjusting the required premium contribution percentage used for assessing affordability exemptions from the individual mandate. The ACA requires that the current 8 percent of income contribution be adjusted each year to reflect the excess of the rate of premium growth over the rate of income growth between the preceding calendar year and 2013, meaning that the required contribution percentage will increase so long as premiums continue to rise faster than income.

We recommend that CMS delay implementing any increases in premium contributions based on indexing for the foreseeable future. Current proposed income and premium growth numbers places the index at 1.005. This would increase the income contribution level from 2% to 2.01% and on the higher end from 9.5% to 9.56%. The 8% contribution would increase to 8.05%. Implementing these adjustments would involve significant technical and administrative costs, such as revising online calculators and coding for marketplace applications.

§ 155.1400 Quality rating system.

We strongly recommend that QHP issuers are required to collect and report the necessary

information to implement the QRS pursuant to section 1311(c)(3) of the Affordable Care Act. We suggest that the QRS on quality measures focus on what matter most to patients, and that the way in which data is presented to consumers is meaningful and easy to understand.

It is critical that consumers have a clear understanding of what goes into the quality measures so they are useful in choosing a health plan. **We recommend that the QRS be collected and reported at the metal tier level, not only at the product level.** The consumer experience will be different for plans at different metal levels, and this information will be critical in determining how well QHPs are meeting consumer needs.

Below are a few examples of measures that would be meaningful to consumers:

- Measures of member experience:
    - How long is wait time for appointments
    - How far is travel to clinicians
    - How likely are enrollees to report that they are confident that they have the knowledge and resources to manage their health
- Measures of primary care system / coordination:
    - How likely is a person to be admitted or readmitted to the hospital for treatment that could be provided in a doctor's office or community setting
- Measures of clinical quality:
    - Of those admitted to a hospital, how likely are they to develop a preventable complication or infection during their stay
- Measures of plan efficiency / affordability:
    - Does the plan exceed the required medical loss ratio (MLR)

Health equity is a critical part of improving population health over time. Collecting, analyzing and reporting data on health outcomes by race, ethnicity, primary language, gender identity and sexual orientation is crucial to understanding how quality differs between demographics. Data regarding race and ethnicity is usually not collected properly, and in many cases not collected at all. But reliable data is essential to identify the type and severity of disparities, causes, interventions needed, and track results. Therefore, **we recommend that QHPs report and publicly post their progress in improving health outcomes of enrollees by race, ethnicity, primary language, gender identity and disability.** These reports should also include data on related complaints and appeals to help consumers make decisions on health plans that improve quality by making progress in decreasing health disparities.

We recommend CMS require QHPs to measure quality of pediatric services as an area of focus distinct from adult quality measurement. Children's interaction with the health care system is different from adults' use of health care. Children represent a fundamentally distinct population on four dimensions: development, dependency, differential epidemiology, and demographics. Because of these differences, the children's health advocacy community is deeply concerned about access to appropriate pediatric services—particularly pediatric subspecialties—within the adult and family QHPs. As such, we **urge CMS to adopt a requirement that adult and family QHPs report data stratified by pediatric and adult groups.**

We recommend CMS include outcomes related to substance use disorders in the QRS framework. Although behavioral health measures have been endorsed by some of the authorities relied upon in the QRS, those measures were not included. For example, the National Quality Forum endorses Measure 004 which provides:[1]

- **Initiation of Alcohol or Other Drug Dependence (AOD) Treatment**. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- **Engagement of AOD Treatment**. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

For further information, please refer to Community Catalyst's comments on the framework for the QRS at http://www.communitycatalyst.org/resources/comment-letters/document/CC_Quality_framework_Exchange_comments_FINAL.pdf

Part 158 – Issuer use of premium revenue: reporting and rebate requirements

The proposed regulations make several temporary changes to the medical loss ratio regulations, including exempting the additional payments to insurers through risk corridors and portions of the ICD-10 conversion costs, and increasing the calculation allowed for claims for transitional policies. These changes will ultimately decrease the pressure that the MLR requirement places on insurers to keep premiums down. We strongly urge CMS to keep these changes temporary, and urge CMS to in no way consider extending them or making future changes that would undermine the importance of the MLR as a tool for keeping premium costs in check.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Christine Barber, Senior Policy Analyst, at cbarber@communitycatalyst.org or 617-275-2914.

Respectfully submitted,

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[1] See https://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Behavioral_Health_Measures.aspx