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

RE: Comments on CMS-9989-P—Proposed Rule on the Establishment of Exchanges and Qualified Health Plans (Docket ID Number: HHS-OS-2011-0020)

To Whom It May Concern:

Community Health Councils (CHC) writes to share comments on the Department of Health and Human Services' notice of proposed rulemaking regarding the Establishment of Exchanges and Qualified Health Plans as required by the Patient Protection and Affordable Care Act of 2010. CHC is a non-profit community-based health promotion, advocacy, and policy organization committed to improving health and increasing access to quality healthcare for uninsured, under-resourced, and underserved populations in South Los Angeles County.

When the Affordable Care Act was signed into law, an estimated 32 million Americans were instantly provided with the peace of mind that they would be guaranteed access to quality, affordable, culturally and linguistically appropriate health coverage in their lifetime. Central to the Act was the vision of a marketplace where consumers would come first and where product competition would drive quality and improvement resulting in lower healthcare costs for all Americans. While being just one of the key pathways to coverage, the success of the Affordable Care Act will be determined by the ability of millions of Americans to enroll in and access coverage in the Exchanges. Bearing this reality in mind, Community Health Councils would like to offer the following comments and recommendations to inform the final regulations related to health Exchanges and qualified health plans.

As a community-based consumer advocacy organization, we believe Exchanges and QHPs should:

- Be designed on policies and systems that seek to bring consumers readily into coverage rather than screen them out;
- Provide sufficient information to allow families to compare and understand all available healthcare coverage options;
- Provide a simple, easy enrollment process and procedures that enable families to obtain and maintain health coverage and navigate the healthcare system;
- Provide equitable access to quality healthcare services; and
- Close the gap between the coverage rates of racial and ethnic minorities and whites.

Thus, our comments are focused on issues we feel impact consumer interests as outlined in 45 CRF Part 155 and Part 156 of the proposed regulations.

Subpart B – General Standards Related to the Establishment of an Exchange by a State

In order to ensure that an Exchange works for consumers, the Exchange must be comprised of individuals and/or entities committed to creating a culture of coverage where no individuals are denied access to care because of income, geographic location, language or other factors. The governance structure must be transparent to facilitate ongoing policy development and address issues that may arise in the Exchanges. To that end, we raise the following concerns and recommendations as they relate to Exchange governance.

§155.105 Approval of a State Exchange

The State Plan Amendment Process plays an important role in protecting consumers from drastic changes to programs that could limit access and quality of care. We support the recommendation that HHS require States to submit written requests to make changes to their Exchange Plan and that changes not take effect until approval from HHS is received, similar to the State Plan Amendment process for CHIP and Medicaid.

§155.110 Entities eligible to carry out Exchange functions

In line with the vision of the Affordable Care Act, we commend HHS for requiring that an Exchange's governance structure represent consumer interests and not be comprised of a majority of voting individuals with conflicts of interest. However, we recommend that HHS **strengthen the protections outlined under §155.110 (c) (3) by explicitly prohibiting** anyone who works for, consults with, represents, is a member of an association of, or is on the Board of a health issuer or insurance broker from serving on the Board of an Exchange.

While a significant portion of the Exchange Board's duty will require a level of understanding and familiarity with insurance systems, a working knowledge can be easily learned and should therefore not preclude or limit the composition of the Board. A level of expertise from the perspective of the potential consumer is critical to the successful design and implementation of an Exchange. There are numerous examples across the nation of failed starts as a result of minimizing the importance of the consumer's response and experience with new programs including the transition of Medicaid to a managed care format and the roll out of Medicare prescription drug program. Of equal concern is the knowledge of and expertise of working within the intended consumer population. Therefore, Exchange Boards should be required to reflect the diversity of the potential population. Board members should include individuals representing the interests of various communities including ethnic and Native communities, limited English proficient communities, individuals with disabilities, and representatives should vary by geographic area (i.e. urban, rural).

Amend §155.110 (c) to add: (5) Reflects the diversity of the potential population including ethnic and Native communities, limited English proficient communities, communities with limited literacy capacity, individuals with disabilities, and representatives from various geographic areas.

Furthermore, consumer representation on the board can help mitigate potential or perceived conflicts of interest if the representation goes beyond one token or symbolic seat and provides sufficient representation to bring a balanced perspective to an otherwise easily dominate corporate orientation. We recommend that HHS require Exchange Boards to have at least 20% consumer representation.

Amend §155.110 (c) to add: (6) Is comprised of at least 20% consumer representation including consumers of qualified health plans, Medicaid enrollees, and Basic Health Plan enrollees, where applicable.

Under §155.110 (d) regarding Exchange governance principles, we strongly support provisions that Exchanges must disclose financial interest of the Exchange board or governance structure to ensure the integrity of the program. We also support the recommendation that members of the Exchange governing body must adhere to stringent conflict of interest rules.

Subpart C – General Functions of an Exchange

§155.200 Functions of an Exchange

The Congressional Budget Office estimates that 24 million Americans will be eligible for coverage in the Exchanges. Almost 16 million of the new Exchanges population will consist of individuals who were previously uninsured. Individuals eligible for coverage may fluctuate between private and public coverage due to life changes. We therefore recommend the core functions of an Exchange include collaboration with other public programs and entities. Requiring the Exchange to work with existing agencies that serve low-income communities such as health education and outreach, transportation, housing, and education entities would not only ensure consumers and “hard to reach” populations obtain information about health coverage, ideally it should facilitate coordination between the Exchange and agencies and departments to address the multiple social and economic factors that impact health and well-being.

Amend §155.200 to add: (g) *Coordination and collaboration.* Exchanges must actively work with other public programs and entities, particularly entities serving low-income communities, to promote continuity and quality of care for potential enrollees.

General Comment Regarding the Functions of an Exchange: Understanding that quality activities of an Exchange (*§155.200 (f)*) will be provided in future rulemaking, we recommend that HHS require Exchanges to conduct assessments of compensation for brokers, agents, and Navigator entities to guard against steering of qualified individuals, employers, and employees into select qualified health plans. Exchanges should also conduct reviews of application and enrollment activities to identify and resolve barriers, disparities in enrollment activity between populations and geographic areas and enrollment levels across QHPs.

§155.205 Required Consumer Assistance Tools and Programs of an Exchange

The required consumer assistance tools and programs outlined in this section provide strong steps forward in making sure all individuals get the help and information they need to obtain health coverage. However, Community Health Councils believes that consumer assistance must go a step above and beyond enrollment to promote retention of coverage and utilization of services in order for Exchanges to truly drive down cost, ensure access, and promote better health outcomes. Timely and effective enrollment into coverage hinges on the tools consumers have available to make informed decisions about the benefits, health plan and provider that fits their personal needs and/or the needs of their family. Therefore, we offer the following recommendations:

Under §155.205 (a): We recommend Exchanges be required to make available a 24-hour call-in center. Providing 24/7 customer support will ensure that individuals who work outside the traditional 9am-5pm schedule will be able to get the assistance they need. While the regulations require that the call-in center be available during evening hours, consideration for families and individuals with multiple jobs requires

broader access. Additionally, with more than 21 million U.S. residents speaking English less than “very well,” access to interpretation services for limited English proficient individuals will be critical.¹

Amend §155.205 (a) to read “The Exchange must provide for operation of a toll-free call center that proactively addresses the needs of consumers requesting assistance related to eligibility, enrollment, Navigator entities, appeals and grievance processes through (1) 24/7 assistance, (2) interpretation and translation services for limited English proficient individuals, and (3) appropriate access for individuals with disabilities.

§155.205 (b) Exchanges Should Offer Comprehensive and Consumer-Friendly Websites. Exchange websites should build on the innovation state Medicaid & CHIP programs have pioneered across the nation to enroll people into coverage.² This means “real time” eligibility determinations and ease of enrollment should be central to the development of any Exchange site. In addition to fostering transparency, accountability, and ease of choice of QHPs for consumers, websites should provide information in plain and easy to understand terms at a 5th or 6th grade reading level as well as video options for low literacy users.

Too much information could overwhelm potential consumers and discourage enrollment in the Exchange. While we support HHS’s provisions requiring an Exchange website to show quality ratings information, Medical loss ratio information, transparency of coverage measures, and financial information, we feel some of these elements may be more relevant to employers seeking coverage for their employees versus the information critical to decision-making by consumers. We recommend the website differentiate and provide separate sets of information for the two intended purchasers.

To assist consumers make an informed decision, we recommend **Exchange websites under §155.205 (b)(1) include the following information on each QHP** : (i) premium and cost-sharing information; (ii) summary of benefits and coverage information; (iii) QHP coverage levels (bronze, silver, gold, platinum, catastrophic); (iv) enrollee satisfaction information; (v) quality ratings; (vi) up-to-date searchable provider directory; and (vii) eligibility requirements and standardized appeals and grievance procedures.

Provider directories should be dynamic tools that allow consumers to enter zip code or mailing address information to view providers based on geographic proximity, language access (based on defined threshold language standard), access for individuals with disabilities, and any special certifications or qualifications (e.g. board certified, etc.). This feature should help consumers compare QHPs to facilitate proper plan selection.

We commend HHS for requiring Exchange websites to provide meaningful access to persons with limited English proficiency. We support the inclusion of clarifying language which lists specific elements which must be provided by Exchanges.

Amend §155.205 (b)(2) to add at the end of (2): “including: (i) Translating the Exchange’s website into the state’s threshold languages when a significant number of LEP individuals are served; (ii) Taglines in at least 15 languages directing LEP enrollees to translated documents or telephonic assistance in oral interpretation; (iii) Links to translated documents; and (iv) Information for LEP consumers about how to obtain oral language assistance.”

¹ U.S. Census Bureau 2000.

² Kaiser Commission on Medicaid and the Uninsured. *Online Applications for Medicaid and/or CHIP: An Overview of Current Capabilities and Opportunities for Improvement*. June 2011.

As part of the effort to streamline and simplify requirements, paperwork and systems, Exchanges should create simplified methods for consumers to pay their premiums. In California systems like California Public Employees' Retirement System which manages retirement benefits for more than 1.6 million public employees, retirees, and their families and the Healthy Families Program (California's CHIP), beneficiaries pay their premiums directly to one source versus to the health plan. This reduces administrative burdens for health plans and allows consumers to maintain the same payment source no matter what changes may occur with their plans. Building on the concept of the "one-stop-shop", the website and administrator for the Exchange should represent the centralized payment system for all related cost. Exchanges should also offer a variety of payment options and credits for payments paid in advance.³

Amend §155.205 (b) to add: (7) Allows consumers to make their premium payments through the Exchange website, a central call center, mail, bill pay centers, pharmacies and provide a variety of payment options including but not limited to electronic checks, credit card, debit card and on-line banking services.

Recognizing that not all consumers have the same availability of time or Internet access, CHC recommends that HHS require Exchange websites to provide a feature whereby consumers and Navigators can store and edit application information online. Currently 29 states allow Medicaid/CHIP enrollees to create an online account and store their information to complete their application at a later date meaning a majority of states are already familiar with this feature. The online account feature should also allow consumers to monitor the progress of their online application from the point of submission until approval or termination. If necessary, Exchange websites should provide qualified individuals with an electronic signature or PIN to complete their application.

Furthermore, we recommend that the online website allow Navigators to store information regarding individuals they enroll into the Exchange and that Navigators be able to access applications initiated by qualified individuals as they complete the application. Providing this feature will allow enrollees and Navigators to instantly connect and trouble-shoot issues experienced by an enrollee during the application process without having to physically be in the same room.

Amend §155.205 (b) to add: (8) Provides the ability for consumers and Navigators, and when applicable Exchange qualified insurance brokers and agents, to store and edit relevant application information for enrollment and tax credit and cost-sharing subsidies through the use of an electronic account or PIN. This information storage feature should include a case management feature for Navigators, consumers, and Exchange qualified insurance brokers and agents. Additionally, consumers should be able to select which language(s) and the format(s) they prefer receive information in (i.e. standard mail, phone call, email, social media, text, large font, etc.).

Additionally, in order to maximize enrollment in state Exchanges, we recommend the regulations codify the requirement that state Exchanges provide culturally and linguistically competent consumer assistance in-person, telephonically, and through contracts with community groups as required under Section § 155.210.

Amend §155.205 (d) by moving the section up to (a) and to read as follows: §155.205 (d) – Consumer assistance. “The Exchange must have a consumer assistance function, including the Navigator program described in section 155.210, and must refer consumers to consumer assistance programs in the state when available and appropriate. All telephonic and in-person consumer assistance functions must be provided in a culturally and linguistically appropriate

³ CHC Exchange Comments Fall 2010

manner including the provision of translated materials in threshold languages and oral assistance in any language to limited English proficient consumers.”

§155.205 (e) outlines outreach and education activities. **We recommend codification of the requirement that Exchanges must include broad-based, multi-lingual outreach and education strategies.** With screening and eligibility determinations set to start in October of 2013, we recommend HHS provide a clear timeline for states regarding outreach and education activities for Exchanges (whether state or federal). Prior to engaging in outreach and education activities, Exchanges should be required to research areas with the greatest concentration of uninsured individuals in order to equitably distribute resources to maximize enrollment by those most in need of coverage.

Outreach and education campaigns must be culturally and linguistically appropriate and utilize a wide range of traditional mass media and new marketing strategies. Federal technical assistance would be helpful in developing standardized, “user-friendly” campaign materials and formats for presenting coverage options similar to SCHIP. However, these materials should be adaptable for specific populations and regions. They should also be thoroughly vetted by consumers and other stakeholders prior to implementation at the Federal and State level.

The federal government should play a role in the public information campaign as it did with CHIP. This should include sponsoring public service announcements, garnering public figures as national spokespersons; and providing a national information website and call center that directs consumers to their state program.

The use of technology and mass media must be supported by an equal investment in outreach and education at the community level to ensure all individuals and families are informed and have access to all of the available programs. Community outreach and education is necessary to reach those who are hesitant, need more information or assistance, are “hard to reach”, or are otherwise marginalized. To provide this service and build this capacity, the Exchange should capitalize and build upon existing statewide networks of organizations that provide already provide enrollment services for Medicaid, CHIP and other public health programs.

§155.210 Navigator Program Standards

We support language as listed under this section. However, we seek to clarify and expand upon these provisions. Since Navigators will be the gateway to coverage for millions of consumers, it is critical that Navigator grants be awarded to entities that have a successful track record of enrolling various communities into coverage. This will require Exchanges to set comprehensive training and certification standards that provide for ongoing quality improvement.

In addition to the provisions listed in §155.210 (b)(1)(ii), HHS should explicitly state that entities wishing to be Navigators must show a history of successfully enrolling the eligible population, including culturally and linguistically diverse communities, individuals with disabilities, and communities with varying literacy capacities.

Under §155.210 (b)(1)(iii), we are strongly opposed to language which would require Navigator entities to be licensed as such licensure fees would likely create a cost barrier for entities and individuals interested in being Navigators, and limit an Exchange’s choice of Navigator entities. We recommend the regulations require Navigator entities to meet state or Exchange training and certification requirements. Training and certification requirements must provide a standardized curriculum with clear learning objects that provide the technical knowledge and skills needed to effectively assist clients while remaining current on policy change in the federal, state and county regulations. Trainings should provide opportunities for entities to share challenges and strategies for troubleshooting with clients and dealing

with the health care system. Specialized training programs should also be developed to enhance the skill capacity of Navigator staff for more complex issues (i.e. encouraging clients to utilize preventive services). States should have separate funding for training organizations to provide these services to organizations. Furthermore whereas we recommend standardization in curriculums, states and regions should be afforded the ability to adapt the curriculums, vetted through local community based organizations and health advocates.⁴

We support the inclusion of language requiring Navigator staff to complete state approved training and demonstrate competency in the Exchange, Medicaid, and other public programs and the private insurance market in the state. Such standardization will not only further the goal of seamless enrollment into the appropriate coverage, ideally it should help states leverage the availability of federal funds for Medicaid and other programs by conducting comprehensive outreach and education campaigns highlighting various public services for individuals (including the Exchanges).

Amend §155.210 (b)(1) to add: (v) Complete state approved training and demonstrate competency in the Exchange, Medicaid, and other public programs and the private insurance market in the state.

In response to the request for comments on determinations of conflicts of interest, Navigator Entities should be required to submit an annual statement of financial interest and conflict of interest identifying the source of compensation for enrollment and brokerage activity in and outside of the Exchange. In addition to prohibiting insurers from serving as Navigators, we propose that HHS expand the list of parties that would be considered conflicted and prohibit subsidiaries of insurers or insurer associations from serving as Navigator.

Amend §155.210 (b)(1) to add: (vi) Navigator Entities must submit an annual statement of financial interest and conflict of interest identifying the source of compensation for enrollment and brokerage activity in and outside of the Exchange to the Exchange Board.

We support the recommendation that Exchanges must contract with at least two of the entities listed under **§155.210 (b)(2). We strongly recommend that HHS codify that Exchanges must contract with at least one community, consumer-focused non-profit organization to perform Navigator duties.**

Given that the success of the Exchanges depends on the size and pool of covered individuals, every attempt should be made to guide qualified uninsured individuals into coverage through the Exchange. We applaud HHS for barring Navigator Entities from receiving compensation from issuers for enrolling individuals into a QHP. However, we are concerned that if Navigator Entities are allowed to receive compensation for enrolling individuals into coverage in non-QHPs, Exchanges may become vulnerable to adverse selection. Therefore, **we recommend that §155.210 (c)(2) explicitly state** that Navigators are prohibited from receiving compensation from insurers for enrolling qualified individuals or employers in non-QHPs outside the Exchange. This prohibition would not bar Navigator Entities from receiving federal or state grants awarded for the purpose of enrolling individuals in Medicaid, CHIP or other public plans.

Given that some community based organizations obtain funding from health insurers for educational and other health activities, **we recommend HHS to clarify that this language will not preclude community-based Navigator Entities from receiving grants from insurers for activities unrelated to enrolling individuals and employees in QHPs.**

⁴ CHC Exchange comments Fall 2010.

Navigator Programs Must Build Upon Existing Local Enrollment Infrastructures and Best Practices. Since 1998, the California's infrastructure of Enrollment Entities and their Certified Application Assistants has helped thousands of children and families obtain coverage. CHC envisions that the role of Navigators will be similar to the role CAAs and EEs have played for CHIP in our state. We recommend Navigator duties reflect best practices developed over 13 years of experience from CA's CHIP enrollment infrastructure. **Amend §155.210 (d) to read as follows:**

(d) Duties of a Navigator. An entity that serves as a Navigator must carry out a comprehensive set of duties to ensure qualified individuals are enrolled in coverage, utilize their services, and retain continuous coverage. Therefore, Navigators perform at least the following duties:

- (1) Maintain expertise in outreach, eligibility, enrollment, retention, utilization, and grievance procedures for health programs and conduct public education activities to raise awareness about the Exchange.
- (2) Provide information and services in a fair, accurate, impartial and culturally and linguistically appropriate manner including individuals with disabilities. Navigator entities must provide information about all health programs and should refer individuals to additional social service resources in the community.
- (3) Facilitate easy enrollment in QHPs and public health programs by providing screening and application assistance. They should also assist families with all activities to ensure they are able to maintain their coverage.
- (4) Assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.
- (5) Provide case management & client support upon successful completion of an application. Navigator entities must follow-up with enrollees at certain designated times to ensure successful enrollment, determine utilization status, identify barriers, and work with them to resolve any issues.
- (6) Advocate for clients experiencing problems, who have operational questions, need help filing and following-up on grievances, and need help utilizing services. Entities should provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage in a way that is culturally and linguistically appropriate including individuals with disabilities.
- (7) Provide all information in a manner that is culturally and linguistically appropriate to the needs of the population being serviced by the Exchange, including individuals with limited English proficiency, limited literacy level, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. Interpretation services and translation of all materials should be made available to enrollees requiring those services.
- (8) Adhere performance standards including benchmark indicators to ensure entities are working to enroll as many qualified individuals as possible into coverage and helping individuals maintain coverage.
- (9) Document all activities provided to a client via the website/case management system provided by the Exchange.

Navigators will be essential during the initial enrollment period, which will begin in October of 2013. Therefore, CHC recommends that HHS require Navigator programs be operational by the spring of 2013 as Navigator entities will need to conduct extensive outreach and education activities prior to the delivery of open enrollment notices in August of that year. To facilitate the timely launch of Navigator programs, Exchanges will need to award Navigator funding grants a year to six months in advance of the open

enrollment period. **We recommend HHS reconsider financing restrictions for Navigator programs outlined under §155.210 (e).** Should HHS maintain its stance, we recommend:

Amend §155.210 (e) to read as follows: “*Funding for Navigator grants.* Funding for Navigator grants may not be from Federal funds received by the State to establish the Exchange. States maintain the option of collecting QHP assessment fees prior to January 2014 to make funding available for Navigator grants. In such instances, early QHP assessments may 1) be based on the issuer’s current market share; and 2) the up-front charges may be considered a pre-payment of the actual assessments due from the issuer in 2014.”⁵

§155.220 Ability of States to Permit Brokers

We support the provision that states have the option of working with insurance brokers and agents to enroll qualified employees and employers in the Exchange given the expertise brokers and agents have with coverage in the small group market. That being said, we have similar concerns regarding adverse selection resulting from insurance broker/ agent compensation. While we understand insurance brokers and agents will not receive any funding from the Exchange for enrolling qualified employers and employees into coverage, we are worried that compensation from health issuers to brokers/ agents may result in the steering of qualified employers and employees into certain plans only. Thus, we recommend that just as is required of Navigators, brokers/ agents must obtain certification/ qualification from the Exchanges in order to enroll qualified employers and employees into QHPs.

We recommend §155.220 be amended to read as follows:

(a) *General rule.* States that permit agents and brokers to provide the duties listed under §155.220 are required to implement appropriate broker/ agent licensing, certification, qualification, or other standards in accordance with stringent conflict of interest rules prescribed by the State and/or Exchange. Licensing, certification, or qualification standards should include those (as amended in this comment letter) under §155.210 (b)(1)(i-vi). States may not provide any form of compensation to brokers/ agents for their enrolling a qualified employee or a qualified employer into QHPs. Agents and brokers will continue to receive compensation as they do today, however, an agent or broker may not steer enrollment into a specific QHP as a result of that compensation. Exchanges must establish a process to ensure applicants are screened for Medicaid eligibility and Exchange tax credits and cost-sharing subsidies; for conducting quality reviews of broker and agent compensation including an assessment of the compensation brokers/ agents receive from health plan issuers for enrolling qualified employers and employees into coverage. Appropriate action should be taken against brokers/ agents found to be denying proper information to consumers regarding Medicaid eligibility, eligibility for tax credit and cost-sharing subsidies in the Exchange, and/ or steering enrollment into a specific QHP. Meeting such requirements, brokers and agents may perform the duties listed under this section.

Similar to Navigator entities, Exchange qualified/certified insurance brokers and agents should have access (i.e. log-in information) to the Exchange website and document application and enrollment activities for each client. Using the website tracking system will allow the Exchange to track barriers faced by consumers and steering by Navigators, agents, and brokers.

We recommend §155.220 (a) be amended to include: (3) Document all activities provided to a client via the website/case management system provided by the Exchange.

⁵ Institute for Health Policy Solutions, August 2011, Memo to the California Health Benefits Exchange Board.

Amend §155.220 (b) to read as follows: *Web site disclosure.* The Exchange may elect to provide information regarding certified or qualified licensed agents and brokers on its Web site for the convenience of consumers seeking insurance through that Exchange.

§155.230 General Standards for Exchange Notices

We support the provisions listed under this subsection. As noted under our comments regarding Exchange websites, notices to enrollees should be sent according to their preferences (i.e. mail, email, phone call, etc.). We believe HHS should clarify that based on the language consumers request to receive information in, appropriate translation of materials should be provided in a low literacy level. In cases where translation is not available, consumers should be provided with information about the availability and steps to obtain interpretation services.

Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

The task of enrolling 24 million individuals into coverage in the Exchanges will be daunting to say the least. When thinking of enrollment, it is critical to keep in mind that the goal of the Affordable Care Act is to fundamentally shift the way millions of Americans experience access to coverage from one that is based on whether or not someone qualifies for care to one that assumes eligibility and rather seeks to find the kind of care that meets the needs of the individual. In support of this vision, we offer the following recommendations to promote enrollment in and retention of QHP coverage.

§155.400 Enrollment of Qualified Individuals into QHPs

Eliminating barriers to enrollment will be critical to pulling a diverse pool of individuals into the Exchanges. We recommend **§155.400 be amended as follows:**

(a) *General requirements.* Exchanges must work hard to minimize denials of eligibility for public and subsidized plans and develop systems which facilitate accurate real-time eligibility, enrollment, and verification of records. Such a system should provide real-time data matching between Medicaid, CHIP and the Exchange and the appropriate state and federal agencies such as the Social Security Administration, the IRS, and state employment agencies. Using said system, the Exchange must accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP in accordance with the standards established in accordance with § 155.200(c) of this subpart, and must—

- (1) Notify the issuer of the applicant’s selected QHP; and
- (2) Transmit information necessary to enable the QHP issuer to enroll the applicant.

(b) *Timing of data exchange.* The Exchange must:

- (1) Send eligibility and enrollment information to QHP issuers instantly or on a daily basis; and
- (2) Establish a process by which a QHP issuer verifies and acknowledges the receipt of such information instantly or on a daily basis.

(c) *Records.* The Exchange must maintain records of all enrollments in QHPs through the Exchange and submit enrollment information to HHS on a monthly basis.

(d) *Reconcile files.* The Exchange must reconcile enrollment information with QHP issuers no less than on a monthly basis.

§155.405 Single Streamlined Application

To simplify and maximize enrollment, universal applications should make the distinctions between Medicaid, CHIP and Exchanges “invisible” to families. Should States continue to keep separate agencies to administer these programs, these agencies should have the ability to electronically transition applications and all necessary documents to another program in real time and without any burden on the

client. The Exchange enrollment systems should be based on best practices and innovations that ease enrollment procedures and create a seamless transition between public and private programs.⁶ It is also important that the use of the data and data matches be limited to verification of eligibility for health benefits and not the exchange of information for other purposes (e.g. immigration, tax collection).⁷

§155.410 Initial and Annual Open Enrollment Periods

If the experience of the roll out of the SCHIP program holds true in the case of the state Exchange – achieving desired enrollment levels in the program will take time and a significant investment of resources. There will also be a level of distrust as well as inevitable “glitches” in the system the first year which must be overcome. It will be important to recognize that not every consumer will have the expertise and knowledge necessary to make the best choice of plan for themselves and their families.

Therefore, we strongly recommend ***§155.410 (b-f) be amended to reflect the following recommendations.*** Ongoing open enrollment should exist for at least the first three years of the program for individuals and groups – and no less than quarterly going forward. Annual renewals for individuals would therefore be based upon their enrollment date as is the case in the Medicaid and CHIP program. The annual renewal for groups should also be based on the date of enrollment for at least the first three years. We agree that individuals and groups should be afforded the opportunity to change plans at least one time annually and ability to change plans for good cause.⁸

We support the recommendation that notices regarding the initial and annual open enrollment periods be sent no later than 30 days prior to the start date. We recommend that it be required that notices include information regarding the date annual open enrollment begins and ends; resources for consumers to gain more information about their plan/ QHPs (consumer assistance tools); and other relevant information such as interpretation/ translation services (if not already provided). Additionally, reminder post cards or follow-up phone calls should be conducted no later than 15 days prior to the start date.

In cases where individuals fail to select a QHP or are disenrolled from a QHP because the QHP is no longer offered, individuals should automatically be enrolled into coverage that is comparable in terms of benefits, access to providers, linguistically and culturally appropriate care and cost. A review of an enrollee’s utilization information should inform this process to promote quality and meaningful continuity of care whenever possible. Individuals automatically enrolled into coverage should have a 90-day grace period to change or keep their coverage.

§155.420 Special Enrollment Periods

We commend HHS for providing strong consumer protections under the outlined special enrollment periods. In regards to the trigger events and the start date of the 60 day special enrollment period, we recommend that HHS codify that the start of the special enrollment period be based on the date that the enrollee provides notice to the Exchange regarding the specific event/ life change. On the issue of requiring enrollees to stay within a specific coverage level during special enrollment, we are concerned this might force some individuals and families to maintain coverage that no longer meets their needs or is too costly thereby increasing the risk of medical bankruptcy and financial strain. We recommend that HHS allow individuals to, at the very least, have a process whereby individuals may request to change their coverage level to reflect their current personal needs provided they can justify the need for the change.

⁶ CHC Exchanges Comments Fall 2010

⁷ Ibid

⁸ Ibid

§155.430 Termination of Coverage

We are pleased to see that this proposed rule affirms the goal of continuous coverage. We recommend that the specified “grace period” for nonpayment of premiums apply to all individuals not only to those receiving advance payments of the tax credit. In addition, we recommend that CMS encourage states to develop methods for simplifying the premium payment process and prevent unintended churning. Such methods can include automatic bank or pay check withdrawal, payment by mobile device, and other payment practices common in the commercial market.

Access and Quality of Care

With an estimated 1 to 2 million Californians expected to be eligible for coverage in the Exchanges, access and quality of care will be important factors for California and other states to consider as they get ready for January 2014. Realizing the promise of coverage will not be easy and it will be the job of Exchanges to ensure that populations who have historically not had access to care are able to see a doctor when they need one in their community. Exchanges must build upon and utilize existing provider networks to promote a strong health infrastructure that creates access regardless of where an individual lives.

§155.1050 Establishment of Exchange Network Adequacy Standards

Exchanges Must Ensure an Adequate Network of Providers. An insurer’s provider network can influence the quality of care it can provide and its ability to control costs. For enrollees, the number, type, location, and availability of network providers affects access to timely, quality care. Ensuring a strong network of providers is extremely important when considering costs patients face when going outside a plan’s network for care. To promote timely, geographic access to high-quality medical services, the Exchange needs to create incentives and stimulate a more equitable distribution of healthcare resources throughout the state, particularly in rural and underserved urban areas.

Reflecting California’s Department of Managed Health Care standards (California Code of Regulations §1300.51), we recommend HHS codify language that sets specific time frames or geographic proximity to ensure network adequacy standards for QHPs, among them:

- All enrollees must have a choice of no less than 2 contracting or plan-operated primary care providers within a 30 minute commute or 15 miles, whichever is more appropriate for patient ease and accessibility, from their residence or workplace. Each primary care provider (on a full-time equivalent basis) must have a patient panel of no more than 2,000 enrollees per FTE to be included in the determination of the network adequacy. All enrollees must have access to a contracting or plan-operated hospital within a 30 minute commute or 15 mile radius of their residence or workplace. Participating plans must show that this hospital has a capacity to serve the entire dependent enrollee population based on normal utilization, and, if separate from such hospital, a contracting or plan-operated provider of all emergency health care services. Additionally, for urban underserved areas which experience high traffic congestion, the availability of near resources can be a determining factor in positive health outcomes. For cities with high traffic congestion, we ask that the QHPs provide enrollees with a choice of no less than 2 contracting or plan-operated primary care providers within 10 miles of a residence or workplace.
- For urban and rural beneficiaries located in federally designated Medically Underserved Areas or Medically Underserved Populations, participating plans must show a reasonable effort to contract with providers located in those same MUA/MUP regions. The geographical distribution of healthcare resources is a critical factor in timely care, eliminating health disparities, improving quality and lowering costs of care. To the extent possible, participating plans must account for the

maldistribution of these resources by providing provider incentives, similar to programs offered by the federal government, i.e. National Health Service Corps and Health Professional Shortage Areas.

- QHPs should also ensure that there is a complete network of contracting or plan-employed primary care physicians and specialists, each of whom has admitting staff privileges with at least one contracting or plan operated hospital equipped to provide the range of basic health care services the plan has contracted to provide.
- QHPs should offer the full range of ancillary laboratory, pharmacy and similar services and goods dispensed by order or prescription from the primary care provider. Such services must be available from contracting or plan-operated providers at locations (where enrollees are personally served) within a reasonable distance from the primary care provider.

We support the recommendation that Exchanges be required to develop a monitoring process to ensure sufficiency of providers for enrollees. We also encourage HHS to codify that Exchanges must develop a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner (as outlined in the suggested time frames above).

Additionally, health plans in the exchange and their contracted providers should be evaluated by a set of benchmarks to ensure quality services, timely access, comprehensive care, and improved health outcomes. Exchanges should require participating health plans to demonstrate progressive movement towards integrating the principles of a true patient-centered medical home and accountable care organization as criteria for initial and continued participation in the exchange. Payment for services should be linked to performance with an accounting for the acuity of illness and health needs of their respective patient populations. Finally, contracted providers should receive training on how to become a full-scale Medical Home and Exchange beneficiaries should receive ample education on available resources within the Medical Home model.

§156.1055 Service Area of A QHP

Community Health Councils supports the proposed rulemaking which stipulates that a service area for a QHP must cover, at a minimum, a county or group of counties. CHC proposes that this minimum standard be adapted for additional consumer protections by specifying “groups of counties” to be “contiguous” and share a common border. This would ensure that QHPs do not exclude those counties with poorer health outcomes, underserved populations, and vulnerable populations in determining their service area. Access to standardized, affordable and comprehensive health insurance is critical to the elimination of health disparities in underserved communities throughout each State. Service areas must conform to the residents of these counties and must address the unique healthcare needs present in disparate communities.

§156.225 Marketing of QHPs

Recognizing the Affordable Care Act’s provisions will create an overwhelming demand for private health insurance products, we encourage HHS to expand upon the provisions regarding QHP marketing practices. We recommend HHS incorporate similar language as the California Code of Regulations § 1300.61 provisions which would require QHP issuers to:

- File (not less than 30 days prior to use) all advertising, marketing, and solicitation materials published or distributed in connection with enrollment in the plan, including all such materials distributed by solicitors or solicitor firm.
- File two copies of a proposed advertisement to Exchange staff. An advertisement is "filed" when a true copy thereof, accurately showing the final appearance of the advertisement, is received. To minimize the expense of changes in advertising copy, it may be submitted in draft form for

preliminary review subject to the later filing of a proof or final copy, and the later filing of a proof or final copy may be waived when the draft copy is presented in a manner reasonably representing the final appearance of the advertisement. The text of audio or audio/visual advertising should indicate any directions for presentation, including voice qualities and the juxtaposition of the visual materials with the text.

- If an issuer submitting an advertisement requests an order shortening the 30-day waiting period, such order will be issued when an appropriate showing of the need therefore is made.

In response to the request for comment on applying a broad prohibition against unfair or deceptive marketing practices by all QHP issuers and their officials, agents and representatives, we strongly urge HHS to codify such language to protect consumers from deceptive and misleading marketing practices and that the Exchange be allowed to take action against such plans through penalties, decertification, or other actions. This would include deceptive practices related to the misrepresentation of benefits, advantages, conditions, exclusions, limitations or terms of a QHP. We recommend HHS review existing California law as it relates to deceptive marketing of managed care plans and adopt it as appropriate for QHPs in the Exchanges.

Additionally, we recommend that HHS specify that penalties and provisions against misleading or inaccurate marketing practices extend to materials provided in other languages and materials for limited English proficient individuals. QHPs should also be required to develop thorough marketing policies regarding billing, appeals, and grievance protections, consumer support services and preventive health and wellness activities(in addition to enrollment campaigns).

We would like to thank the Department for providing us the opportunity to provide input on policies that will directly impact the lives of children, seniors, families and communities. We look forward to working with you to build upon the strengths of our current healthcare coverage system and to make needed reforms to improve quality, access, and affordability of care for all individuals. We encourage you to continue to engage the public in the development, implementation and evaluation of these and other healthcare reform regulations. Should you require additional information or have any questions, please feel free to contact Sonya Vasquez, Policy Director, at 323.295.9372 extension 235.

Sincerely,



Lark Galloway-Gilliam, MPA
Executive Director