April 21, 2014

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9949–P
P.O. Box 8016
Baltimore, MD 21244–8016

Dear Ms. Tavenner:

As organizations dedicated to the health and well-being of children and families, we welcome the opportunity to comment on proposed rules to implement exchange and insurance market standards for 2015 and beyond. Our comments focus on provisions of the rule devoted to navigators and other assisters, special enrollment periods, and QHP enrollee satisfaction surveys. The ACA can best fulfill its goals when children and families have access to high-quality consumer assistance, when special enrollment periods are available to those who need them, and when qualified health plans disclose their enrollees’ satisfaction. Please see our detailed comments below.

§155 Navigator and assister standards.

§155.206 Civil money penalties for violations of applicable Exchange standards by consumer assistance entities in Federally-facilitated Exchanges.

We support the proposed rule on the application of civil money penalties (CMPs) for violations of applicable exchange standards by consumer assistance entities in the FFM. We believe that the proposed rule strikes the balance in protecting consumers from inappropriate actions by Assisters while not being overly punitive and deterring Assisters from carrying out their responsibilities. We strongly support giving Assisters the opportunity to agree to a corrective action plan in lieu of paying a penalty in appropriate cases.

We recognize that this rule, as drafted, does not apply to assisters operating in states with state-based marketplace (SBMs) nor does it require SBMs to implement similar provisions. Because we are also recommending that §155.285 not apply to navigators and other assisters, we urge you to extend this rule to SBMs.

During the initial open enrollment, we note there were a number of manual “workarounds” to address system problems until fixes were possible. Because open enrollment was so busy, assisters may not have been well informed about these. We raise this point here because assisters should never be held responsible for catching errors that are due to problems in the way application questions are asked or how the information systems are determining eligibility. We trust that CMS would factor in such complicating factors in the
system design or operability before holding assisters accountable or entering into a corrective plan for issues beyond their control.

**Recommendation:** Amend the rule at §155.206 to apply to assisters operating in states with state-based marketplaces, or require SBMs to adopt the federal rules or implement similar provisions.

§155.210 Navigator program standards.

§155.210(c)(1)(iii)(A-F) Entities and individuals eligible to be a Navigator.
State laws governing navigators, non-navigator assisters and certified application counselors have made it difficult, and sometimes, impossible for organizations to serve in these roles or fulfill their duties as required by the ACA. These laws, and their requirements, have had a chilling and financial impact on navigators and assisters. Thus, we strongly support CMS’ proposal to identify specific circumstances when these laws go too far and to provide flexibility under 155.201(c)(1)(iii)(F) for CMS to determine other circumstances that are not explicitly described in 155.210(c)(1)(iii)(A-E).

§155.210(c)(1)(iii)(A)
We urge HHS to strengthen this rule to expressly include insurance agents and brokers who are not otherwise required to provide fair, accurate and impartial information, as discussed in the preamble. This does not necessarily prevent referrals to agents and brokers. States can take action similar to California, where agents and brokers can be certified as enrollment counselors but are required to provide fair, accurate and impartial information about the full range of QHPs. The rule should also note that it is intended to encompass information about the full range of QHPs.

**Recommendation:** Amend the proposed rule 155.210(c)(1)(iii)(A) as follows:

(A) Except as otherwise provided under §155.705(d), requirements that Navigators refer consumers to other entities, including licensed agents or brokers, that are not required to provide fair, accurate, and impartial information about the full range of QHPs.

§155.210(c)(1)(iii)(C)
We particularly support the inclusion of the word “advice” in 155.210(c)(1)(iii)(C) as the use of this word was prominent in boilerplate language that has been proposed and has been enacted in a number of states. We encourage you to retain this language in the final rule.

§155.210(c)(1)(iii)(D)
In some states, navigators have reported difficulty in securing surety bonds because of the unwillingness of carriers to underwrite a business service for which it is difficult to assess risk. We recommend including surety bonds in this prohibition. Based on regulations at §155.420(d)(4) and §155.420(d)(10), CMS has the authority to grant consumers a special enrollment period if there has been misinformation, misrepresentation, or misconduct by HHS, the marketplace, or its instrumentalities, and to establish an appropriate effective
date at §155.420(b)(2)(ii) based on the circumstances. We believe the combination of these rules provide important protections for consumers.

**Recommendation:** Amend the rule under 155.210(c)(1)(iii)(D) as follows.

*(D) Requiring that a Navigator hold an agent or broker license, or carry errors or omissions insurance, or secure a surety bond.*

155.210(c)(1)(iii)(F)

We support the provision under 155.210(c)(1)(iii)(F) allowing CMS to identify other circumstances in which state laws may prevent the application of Title 1 of the Act. We suggest strengthening this by including specific language regarding requirements that set unreasonable time limitations and impose unreasonable costs on navigators as follows:

**Recommendation:** Amend the proposed rule at 155.210(c)(1)(iii)(F) as follows:

*(F) In a Federally-facilitated Exchange, imposing standards that would, as applied or as implemented in a State, prevent the application of requirements applicable to the Federally-facilitated Exchange, including setting unreasonable time limitations on meeting standards or imposing unreasonable costs on navigators.*

§155.210(d)(5-9) Prohibition on Navigator conduct.

§155.210(d)(5) We support the inclusion of a prohibition on charging applicants or enrollees.

§155.210(d)(6) We agree that compensation paid on a per-application, per individual-assisted, or per-enrollment basis provides adverse incentives and invites behavior that is not in the best interest of consumers, whether served by a Navigator or non-Navigator assister. Assistors paid on a per-application basis may have no incentive to ensure that people successfully enroll in coverage. Consequently, their focus may be on finishing the application, without prioritizing any post-application activity such as collecting and submitting paper documents to verify eligibility factors or helping people with more complex cases.

Moreover, we believe that funding models that pay assister entities on a per application, per-individual or per-enrollment basis can also be problematic for the same reasons as they are for individuals and therefore we urge CMS to extend this prohibition to Assister entities in the final rule. Recognizing that at least one state, California, has already invested significant resources in developing an infrastructure to support such models, we believe CMS should allow a transition period to implement this rule, recommending that states must come into compliance by the beginning of open enrollment in 2015 for the 2016 coverage year.

Further, we suggest that CMS assess the experience of Washington State, and other states that have in place a performance or outcome incentive-based compensation model for navigator or non-navigator assisters. It is likely too early to translate lessons learned into
regulatory language but understanding the impact of performance-based incentives is important for future sharing of best practices and potential regulatory oversight.

**Recommendation:** Amend the rule at §155.210(d)(6) as follows:

*Provide compensation to Navigator entities or individual Navigators on a per-application, per-individual-assisted, or per-enrollment basis.*

§155.210(d)(7), §155.210(d)(8) and §155.210(d)(9) We appreciate the intent to block bad actors from engaging in questionable or intentional activities, but entities that are likely to engage in these tactics are outside the purview of this regulation. We do agree that navigators and non-navigator assisters should not be offering inducements or using cold-calling techniques in connection with application assistance or enrollment, but both provisions require additional context and clarity that may be more effectively dealt with in sub-regulatory guidance or contractual agreements, if needed. Generally, we are concerned that these regulations go too far and will inhibit outreach activities that have proven effective in Medicaid and CHIP, such as promotoras going door-to-door and assisting with access to health coverage. (For more information, see: [http://www.latinohealthaccess.net/the-promotora-model/](http://www.latinohealthaccess.net/the-promotora-model/))

§155.210(d)(7)

Regardless of the mechanism used to establish the provision, the prohibition on using promotional items should expressly NOT apply to outreach and public education. Using promotional items are common in outreach and have been used effectively in Medicaid and CHIP to promote awareness of both coverage and consumer assistance. If this rule is retained, we urge you to clarify that promotional items used to promote the availability of consumer assistance, the marketplace, or any insurance affordability program are not barred under this provision.

**Recommendation:** Strike this provision in the final rule. If the proposed rule is retained, amend §155.210(d)(7) as follows to explicitly allow the use of promotional items that promote the marketplace or access to assistance through assisters identified at 155.210, 155.215, and 155.210. Outreach should also be explicitly excluded from this provision if it is retained.

§155.210(d)(7) *Provide gifts, including gift cards or cash, unless they are of nominal value, or provide promotional items that market or promote the products or services of third party, other than the marketplace or access to assistance through assisters identified at 155.210, 155.215 and 155.210, to any applicant or potential enrollee in connection with or as an inducement for application assistance or enrollment as described in 155.210(e)(3).*

§155.210(d)(8)

We agree that navigators and non-navigator assisters should not solicit consumers directly to provide application or enrollment assistance without the consumer’s express permission. We note that there may be “bad actors” that may use these types of techniques inappropriately, but we believe the risk is greater that problematic activity will be
generated by groups acting outside of the scope of an official assister capacity and therefore are not subject to these rules. Generally, we are concerned that these regulations go too far and will inhibit outreach activities that have proven effective in Medicaid and CHIP, such as promotoras going door-to-door and assisting with access to health coverage. (For more information, see: [http://www.latinohhealthaccess.net/the-promotora-model/]. We believe that assisters’ activity related to these types of strategies should operate under some parameters. However, the need for additional context and clarity suggests that this issue may be addressed more appropriately in sub-regulatory guidance or contractual agreements.

**Recommendation:** Strike this provision in the final rule. If the proposed rule is retained, it should be amended §155.210(d)(8) to explicitly exclude outreach.

§155.210(d)(8) Solicit any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling a consumer to provide application or enrollment assistance as described in §155.210(e)(3) without the consumer initiating the contact.

§155.210(d)(9) Organizations have effectively used automated calls for outreach and coverage retention in Medicaid and CHIP. Additionally, organizations that serve as navigators may use automatic dialers for other purposes. For example, healthcare providers may use automatic dialers to remind individuals of appointments or past due payments. If this provision is retained, it is important to clarify that this prohibition is related to navigator activities at §155.420(e)(3). If CMS moves forward with finalizing §155.210(d)(9), it should allow the use of automated calls if an assister has an existing relationship with the consumer, which can be particularly effective in promoting retention of coverage.

**Recommendation:** Strike this provision in the final rule. If the proposed rule is retained, amend §155.210(d)(9) to read:

§155.210(d)(9) Initiate any telephone call to a consumer using an automatic telephone dialing system or artificial or prerecorded voice related to navigator duties as described in §155.210(e)(3), except in cases where the assister has an existing relationship with the consumer.

§155.210(e) Navigator duties.

§155.210(e)(6)(ii) requires that navigators obtain an authorization before obtaining access to the applicant’s personally identifiable information, and that the navigator maintains a record of the authorization provided.

**Recommendation:** We recommend that the FFM identify the period of time for which the authorization is valid (i.e. establish an automatic expiration date, for example, two years after the date of authorization) and a separate period following the expiration during which the navigator or non-navigator entity must retain such records. The Secretary should create a standard authorization form with stakeholder input and provide it as a model that assisters can opt to use rather than
re-creating their own, which can be a considerable expense. The model form should be developed taking into consideration low literacy levels and should be translated by HHS in at least the top 15 languages to meet the language needs in the states served by the FFM. Assistors should also be allowed to use voice recording as an acceptable mode to obtain authorization from consumers they are first assisting over the telephone.

§155.215 Non-navigator assisters.

We generally support aligning navigator and non-navigator assister rules. Our comments in the section above on these provisions apply to this section as well.

§155.225 Certified application counselors.

§155.225(d)(8)(i-v) We support these provisions with the amendments suggested in our comments on the parallel provisions relating to navigators and non-navigator assisters at §155.210(c)(1)(iii). The provision at §155.210(c)(1)(iii)(D) should also apply to certified application counselors.

**Recommendation:** Add the following language at §155.225(d)(8)(iv), and renumber (iv) and (v) accordingly:

§155.225(d)(8)(iv) Requiring a certified application counselor hold an agent or broker license, carry errors or omissions insurance, or secure a surety bond.

§155.225(f)(2) requires that CACs secure an authorization before obtaining access to the applicant’s personally identifiable information, and that the navigator maintains a record of the authorization provided.

**Recommendation:** See our recommendations at §155.210(e)(6)(ii).

§155.225(g)(1). We support the rule prohibiting CAC entities and individual CACs from imposing charges or fees on consumers

§155.225(g)(2). We support the rule to prohibit CACs from receiving compensation from issuers.

While we generally support aligning navigator and non-navigator assister rules, we are concerned that well-intended rules at §155.225(g)(3-6) to deter bad actors will discourage organizations from actively participating as certified application counselors (CACs) designated entities. Given that CACs do not receive federal funding, imposing too many restrictions could simply discourage these organizations from seeking certification with the marketplace, where their activities can be monitored. Organizations that choose not to become a CAC would then be outside the authority of these rules.
Regardless of whether the final rules at 155.210(d)(7-9) are adopted as final, we strongly urge that the proposed rules at §155.225(g)(3-6) not be adopted. If CMS moves forward with finalizing §155.225(g)(6), it should allow the use of automated calls if an assister has an existing relationship with the consumer, which can be particularly effective in promoting retention of coverage.

**Recommendation:** Strike the provisions at §155.225(g)(3-6).

§155.250 Payment of Premium

We strongly support this rule requiring the proration of partial coverage months. We recommend that state-based marketplaces be required to implement similar provisions.

§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 strongly oppose this rule application to navigators, non-navigator assisters or certified application counselors. The preamble suggests that consumer assistance personnel could be subject to civil penalties for providing false or incorrect information under the provisions of the rule that apply to the application process. While this is not explicit in the rule, the preamble states that it should be up to HHS to determine whether it is appropriate to assess a penalty under proposed §155.258 or under proposed §155.206, which provides for civil monetary penalties for violation of Exchange standards by consumer assistance entities operating in the FFM.

It is difficult to see how a consumer assistance entity could be penalized for providing incorrect or false or fraudulent information in violation of 1411(h), because assisters do not actually provide information as part of the process applying for coverage or an exemption. It is certainly conceivable that an assister could cause the applicant to provide incorrect information — in which case the applicant could be able to claim the reasonable cause exemption to the penalty for acting in good faith. In that situation, the assister should be held responsible under §155.206 for violating standards of conduct that apply to consumer assistance entities.

**Recommendation:** Amend the rule at §155.285 (a)(iii)(C)(2) as follows:

> For purposes of this section, the term “person” is defined to include, but is not limited to, all individuals; corporations; Exchanges; Medicaid and CHIP agencies; other entities gaining access to personally identifiable information submitted to an Exchange to carry out additional functions which the Secretary has determined ensure the efficient operation of the Exchange pursuant to §155.260(a)(1); and non-Exchange entities as defined in §155.260(b) which includes agents, brokers, Web-brokers, QHP issuers, Navigators, non-Navigator assistance personnel; certified application counselors, in-person assistors, and other third party contractors.

§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 and minimize or avoid gaps during the transition, and that this ability is not limited to just those people losing employer-sponsored coverage. This provision will be important for families whose rising income makes some members ineligible for Medicaid. Among this group will be parents; providing parents and their dependents with an SEP before other coverage ends will help support continuous coverage and the health and financial well-being of entire families. Moreover, 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 HHS 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 (that previously barred them from getting subsidies) 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 on or 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.

**Recommendation:** 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; or

Changing the policy as we recommend would allow people in the following situations and other situations, including death of a spouse, 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.** Because of their low incomes, 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 or applied for Medicaid if they knew they were ineligible. If people who were in the coverage gap get a job or otherwise 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 now 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 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 (because of the loss of coverage) or because they move after the divorce. But if other such circumstances don’t make them eligible for a SEP, they will have to wait until the next open enrollment period — and often will remain uninsured until then.

- **Workers and their families 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 workers and dependents who have an offer of employer-based coverage but have not enrolled in the coverage, because they find it too expensive. If such a worker loses his or her job and thus loses access to the job-based plan, the individual (and his or her family) could become eligible for Marketplace subsidies because they are no longer subject to the affordability test. But the individual may not be able to enroll in a Marketplace plan outside of open enrollment without the change we are recommending, 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. Someone 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.

§ 155.1405 Enrollee satisfaction survey system

We urge HHS to require that the complete results of the Qualified Health Plan (QHP) Enrollee Satisfaction Survey (ESS) be available for all QHPs in all marketplaces for public viewing. While we support incorporating a subset of ESS results into the rating for each QHP under the quality rating system (QRS) as proposed in Section 155.1405, we do not believe that this practice alone should be considered sufficient to meet the requirements for marketplaces to display ESS results to the public. We strongly believe that, in addition to factoring in ESS results into the QRS rating, all ESS results should be required for public posting on marketplace websites for all QHPs, by metal level.

The ESS, discussed under section 155.1405 (as well as 156.1125) of the proposed rule, represents extensive work, with input from multiple stakeholders, to design a survey that will assess how consumers fare in their QHPs with regard to multiple factors, ranging from their experience getting an appointment with a provider to how that provider serves them to whether cost-sharing in a QHP presents a barrier to accessing care. The ESS is a unique source of this information. Failing to provide its results to the public on marketplace websites means that consumers will know less about how people fare in various health plans before they have to make a choice about which health plan would best meet their needs. Failing to provide its results to researchers and advocates would result in missed opportunities to understand the need for and to implement QHP improvements for consumers.

Great investments have been made to secure federal contractors and vendors to implement the ESS. We believe that the public should fully benefit from these investments and that all marketplaces should be required to post comprehensive ESS results for all QHPs. Given that ESS results will already be tabulated and presented to the marketplaces and the QHPs, it should not present an undue burden to make them accessible to the public, which could benefit greatly from understanding how QHPs perform in all dimensions of the ESS and not just those selected for inclusion in the QRS. Furthermore, given that data will be collected for the ESS by metal level, we believe that the public should have access to ESS results by metal level, as we anticipate that these will differ greatly between, for example, a platinum and a bronze plan.

We understand the need to ensure that consumers are not overwhelmed by too much information about each QHP. However, we believe this speaks to the need to make sure that ESS information is presented well and should not be a reason to prevent complete ESS results from being easily accessible to the public. In order to make this information digestible for consumers, HHS could consider making the full ESS results accessible to consumers by having them “click through” a QHP’s quality rating for comprehensive ESS
information. However, consumers and researchers should also be able to access complete ESS results for any given QHP in a comprehensive and printable format.

Similarly, we believe that HHS should ensure public access to the required marketplace enrollee experience survey for every state, which will provide crucial data to inform needed improvements to the application for coverage, the eligibility determination process, the assistance people have to help them enroll, and other essential marketplace functions.

Thank you for your consideration of our comments on these important regulations.

Sincerely,

Association of Maternal and Child Health Programs
Children’s Dental Health Project
Georgetown University Center for Children and Families