American Cancer Society ☙ Children's Defense Fund/New York ☙ Community Service Society of New York ☙
Make The Road New York ☙Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition
Public Policy and Education Fund of New York/Citizen Action of New York ☙ Raising Women's Voices ☙
Schuyler Center for Analysis and Advocacy

October 31, 2011

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

RE: Comments on proposed rule on establishment of exchanges and qualified health plans.

Dear Secretary Sebelius:

Health Care for All New York (HCFANY) submits these comments on the Notice of Proposed Rulemaking (NPRM) on the establishment of health insurance exchanges for qualified health plans under the Affordable Care Act (ACA). HCFANY is a statewide coalition of 120 organizations which seek to achieve affordable, quality health care for all New Yorkers. We thank you for the opportunity to provide our comments on this fundamental provision of the ACA. Our comments are presented in the order the relevant provision appears in the NPRM.

Part 155: Exchange Establishment Standards and Other Related Standards
Subpart B: General Standards Relating to the Establishment of an Exchange by a State

§155.105: Approval of a State Exchange

This section of the NPRM describes HHS's proposed process for certifying a state Exchange though the federal State Plan Amendment process, which is commonly used by states when they seek to make changes to their Medicaid programs.

Health Care For All New York
c/o Elisabeth Ryden Benjamin, Community Service Society of New York
105 E. 22nd Street, New York, New York 10010
(212) 614-5461

HCFANY Comment: HCFANY appreciates the NPRM's effort to ensure transparency in the review of State Exchange proposals through the State Plan Amendment process. However, we understand that New York has experienced significant delays on its pending state plan process and that this process can be cumbersome and untimely. We urge HHS to adopt a transparent procedure which will require immediate disclosure of state proposals on federal and state websites, and decision-making on all requests within 90 days.

§ 155.110: Entities Eligible to Carry Out Exchange Functions

This section of the NPRM describes HHS's standards for the structure and governance of a proposed State Exchange.

HCFANY Comment: HCFANY agrees with §155.110(3) which indicates that the majority of the Exchange board should represent consumer (and/or small business) interests. However, we do not believe that a simple majority is adequate and envision no circumstance where individuals who do not represent the best interests of consumers should have a governing role related to the Exchange.

HCFANY is grateful that the NPRM is cognizant of potential conflicts of interest that could arise as state health insurance exchanges are established and engaged in decision-making. To this end we urge HHS to strengthen the NPRM to require that no member of the Exchange board should have a real or appearance of a conflict. HHS should clarify that Board members should not receive any direct or indirect compensation from carriers, regardless of whether the carrier's product is sold within or out of the Exchange marketplace. Further, they should not have an affiliation with a carrier, a trade association of carriers, a producer, a third-party administrator, a managed care organization, or any other person or entity in a position to directly contract with the Exchange.

The governing board should include a majority of "consumer representatives," which should be defined as someone who is: (1) a representative of a non-profit organization that advocates for or represents constituencies served by the Exchange, including groups comprised of or representing health care consumers, children, low-income people, racial and ethnic minorities, immigrants, and so forth; or (2) an individual with a history of representing the interests of health care consumers or the constituencies served by the Exchange, with demonstrated expertise on health care issues, including but not limited to a current or former board member, active member, or staff person for a consumer organization, or an academic, writer or researcher. At least one member of the board should be a representative of individual health care consumers, and at least one member should be a representative of small businesses.

§ 155.120: Non-Interference with Federal Law and Non-Discrimination Standards

This section of the NPRM indicates that State Exchanges must not establish rules that violate or conflict with federal laws and rules.

HCFANY Comment: HCFANY agrees with the NPRM's admonition that the State Exchanges must comply with federal law. This is a vital protection for health care consumers who seek quality, affordable health care and should not be weakened in any way.

§ 155.130: Stakeholder Consultation

This section of the NPRM indicates that State Exchanges must establish a regular process for stakeholder consultation.

HCFANY Comment: HCFANY supports the NPRM provision which encourages the regular consultation with various stakeholders. However, we believe the term "educated consumers" is confusing and not apt in this context (for example, this term could be perceived to only refer to an individual who is college educated). We believe that this provision is meant to include the term ***health care consumer advocate*** and we urge HHS to clarify this language to include the following list of consumer advocates: health care consumer advocates, advocates from groups that likewise reflect the diversity of exchange enrollees with respect to race, ethnicity, gender, sexual orientation, immigrant status, disability status, language spoken and so forth. We agree with specifically listing certain groups, such as those listed in §155.130: (b)(experience with facilitating enrollment in coverage); (c)(advocates for enrolling hard to reach populations); and (d) small businesses and self-employed individuals.

We also support the proposal to require Exchange boards to hold regular public meetings, notices of which are to be provided in advance to give the public an opportunity to provide feedback on Exchange policies and procedures. However, we urge the NPRM to include a provision that such notices of public hearings be issued in multiple languages and interpreters for speakers of other languages (including, but not limited to, Spanish) must be present at those hearings.

§ 155.160: Financial Support for Continued Operations

This section of the NPRM describes mechanisms for funding a State Exchange.

HCFANY Comment: HCFANY supports §155.160(b)(2) which indicates that states may otherwise generate funding for Exchange operations. HCFANY supports the use of general state revenues and/or broad-based revenue sources for Exchange operations. We do not believe that user fees should be the sole source of funding, as they may be both inadequate and undermine the viability of the Exchange (to the extent that they increase the prices of QHPs beyond their non-QHP competitors).

Furthermore, we urge HHS to note explicitly that revenue-generating measures such as New York's Health Care Reform Act (HCRA) tax, which is a broad-based provider assessment on both ERISA and non-ERISA plans, have been explicitly upheld under the U.S. Supreme Court and are an acceptable form of financing for State Exchanges. *See* New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995). HHS should signal its support for maximum flexibility to the States seeking creative sources for funding their Exchange.

§ 155.200: Functions of an Exchange

This section of the NPRM outlines the functions of a State Exchange.

HCFANY Comment: HCFANY agrees with HHS's list of the functions of the Exchange. We urge the NPRM to clarify that this list of functions is a floor, not a ceiling. Additionally, we urge HHS to encourage states to use the Exchange as a vehicle for screening and enrolling individuals who are potentially ineligible for a QHP into other benefits, such as a pre-certification program for Emergency Medicaid, state-based hospital financial assistance programs, and so forth. This may be an important option for states, like New York, with significant numbers of immigrants who may not be otherwise eligible for Exchange products.

§ 155.205: Required Consumer Assistance Tools and Programs of an Exchange

This section of the NPRM describes the required consumer assistance functions for State Exchanges.

HCFANY Comment: HCFANY has extensively considered the question of how Exchanges can best meet the needs of consumers through Consumer Assistance and Navigator programs. Our comments in this area are encapsulated in the recently released report by the New York State Health Foundation, *Connecting Consumers to Coverage: The Role of Navigators and Consumer Assistance Programs in Implementing Health Reform in New York*, New York State Health Foundation, (September 2011).

First and foremost, the NPRM should provide more guidance on how CAPs would be funded. As noted below, we support the language in the preamble indicating that Medicaid and CHIP activities by Navigators are eligible for federal funding. We urge the Department to expand on this language, clarifying that consumer assistance programs, as well as Navigator entities, are eligible for federal matching funds for providing services to consumers, regardless of whether they are eligible for Medicaid, CHIP, BHP, or subsidies. All of these programs together make up a continuum of coverage for low-income consumers. In fact, many families will have members who qualify for coverage through different programs on this continuum. The Exchange should be focused on enrolling consumers for these programs, not figuring out how to sort customers by the program they enroll in for reporting. If this is not possible, the Department should develop a simple adjustment mechanism for reporting.

In response to the NPRM, we have the following specific recommendations and/or comments:

- We agree that the Exchange should operate a call center outside of normal business hours and adjust staffing in anticipation of periods with higher call volumes.
- We recommend that the NPRM include specific requirements for these call centers to be able to assist LEP consumers. HHS must ensure that oral communication assistance be provided to all enrollees who access the call center. For LEP enrollees, this will likely entail the use of competent interpreters and/or bilingual call center staff.
- If call centers do not provide in-person assistance, the Exchange should be required to ensure that in-person assistance, including bilingual assistance, is provided through the Navigators and CAPs.
- We agree with the suggestion in the preamble that Exchange websites should allow applicants and enrollees to store and access personal account information.
- We agree with the suggestion that Exchange websites include a feature which allows certified Navigators and/or Facilitated Enrollers and Consumer Assistance Programs, or other "responsible" parties acting on behalf of a consumer, the ability to interact and update the records of individuals they have assisted.
- HHS should develop a model calculator to help consumers compare the cost of coverage for available plans after application of subsidies.
- We agree that the internet website should have the required information listed in the NPRM §155.205(b), at a minimum.
- We agree that the Exchange must be able to make "one-stop" eligibility determinations for public health insurance as is indicated by §155.205(b)(5).

We urge HHS to strengthen the Consumer Assistance provision in §155.205(d). Health reform will fail absent a robust and active Consumer Assistance Program (CAP) in each State. The

NPRM should specify that CAPs should help consumers with appeals and other dispute resolutions, including fair hearings and grievances.

The Department should provide more guidance on the CAP programs, including what minimum functions the CAPs should provide, and how these programs can be aligned with the ACA-established Navigators. HCFANY refers HHS to the report cited above for suggestions to this end.

§ 155.210: Navigator Program Standards

This section of the NPRM addresses the minimal standards state Exchanges must meet when establishing their Navigator programs.

HCFANY Comment: HCFANY urges HHS to revise the NPRM to indicate that a State Navigator program must require that at least one of the two types of entities serving as Navigators include a community and consumer-focused non-profit organization. Only community and consumer-focused non-profit organizations will guarantee access to targeted uninsured populations—the vast majority of which consist of low-income working families. In addition, with adequate resources, consumer-focused non-profits are more likely to ensure that Navigator services are provided in a culturally and linguistically appropriate manner. Additional Navigator grantees should reflect a cross-section of stakeholders.

HCFANY strongly believes that States should develop a uniform training and certification program for Navigators. HHS should create a model training manual or document that sets a floor, but not a ceiling, for state certification programs. These materials can serve as a baseline for the establishment of a consistent, fair, accurate and impartial training and certification program which may be easily adopted and modified to meet the unique conditions in each state. Navigators should be trained about language access policies and procedures, immigrant eligibility for public programs, immigrant concerns, and cultural competency.

HCFANY believes that Navigator entities should be trained and engaged in education activities before the first open enrollment period begins.

HCFANY believes that entities (carriers and brokers) that receive compensation from insurers for enrolling consumers or businesses in non-QHP plans should not be allowed to serve as Navigators. Commissions from insurers for any type of health coverage, inside or out of the Exchange, create a conflict of interest. Moreover, permitting Navigators to continue to receive compensation for non-QHPs sold outside the Exchange could result in adverse selection for the

QHPs in the Exchange, which would drive up costs and reduce participation in the Exchange. Such an outcome would vitiate the goals of the ACA.

HCFANY believes that the text of the NPRM should squarely indicate that Navigators must facilitate enrollment in public insurance for eligible families and individuals. We strongly support language in the preamble that states that Medicaid and CHIP activities by Navigators are eligible for federal funding. This language should be included in the text of the NPRM.

§ 155.220: Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs

This section of the NPRM describes the role of agents and brokers.

HCFANY Comment: As carriers typically do not provide for commissions in New York's individual market, brokers and agents seldom sell products in our individual market (with the exception of Healthy NY and Medicare Supplemental policies).

In order to maximize the opportunity to enroll all New Yorkers into coverage, HCFANY agrees that brokers should be permitted to help prospective enrollees apply for subsidies and enroll in QHPs. However, such brokers must not be able to receive commissions from carriers for enrollments in the individual market, for fear that such commissions would impose undue incentives in the individual market that could undermine the risk pool in the Exchange. We reiterate our concern that entities or individuals—including brokers and agents—which are directly or indirectly compensated by carriers should not receive funding to act as Navigators.

§ 155.230: General Standards for Exchange Notices

This section of the NPRM describes the standards for notices issued by the Exchange.

HCFANY Comment: HCFANY generally supports the direction of the NPRM guidance for Exchange notices. Specifically, HCFANY supports the requirement proposed in §155.230(c) that notices to Exchange users use plain language to provide contact information for customer assistance resources and an explanation of appeal rights. HCFANY believes that plain language requirements should also apply to applications, forms and other documents utilized by the Exchange and provide meaningful access to limited English proficient ("LEP") individuals and persons with disabilities.

While the proposed regulation incorporates the basic critical "accessibility and readability" concepts of plain language, access for LEP persons and for persons with disabilities, we make the following suggestions for improvements to strengthen this section of the NPRM:

- In order to enable consumers to take appropriate action, notices must also describe the specific action that is being taken. States should not be allowed to utilize boiler plate language that identifies multiple programs as potentially impacted or multiple actions as potentially imminent.
- Notices must also include the reasons for the action. States should individualize notices to the greatest extent possible, by identifying specific documents or actions that must be taken if the benefit in question is to be obtained or maintained.
- Notices and other documents utilized by the Exchange should be translated into languages meeting a 5% minimum threshold in the service area (e.g. zip code, or plan service area) and tag lines should be provided in multiple languages on all notices. The Exchange and all QHPs should be required to have language line facilities to serve all customers in their primary language.
- Where appropriate, a telephone number and email address within the Exchange or carrier should be provided where enrollees can get more information or dispute an action.
- Notices should inform enrollees if the action is appealable, the deadline for appeal, and include contact information for a CAP or ombudsman.
- Terms used in notices and other documents utilized by the Exchange should be the same as those published for disclosure by group health plans and health insurance issuers. HHS should require field testing to develop explanations of the more technical terms as a condition of notice approvals.

HCFANY believes that the implementation of the various "health insurance affordability options" envisioned by the ACA presents a range of new options and operational changes that must be explained clearly to enrollees and potential enrollees for health reform to be successful. It is thus more critical than ever that all written materials be presented in a manner that will effectively communicate to the wide range of populations affected.

"Plain language" is necessary not only to clearly notify enrollees of their rights, but to properly explain the various health insurance options that may be available to consumers. Communications geared toward LEP persons and persons with disabilities is not only desirable, but required by various laws, including Section 2001 of the ACA (enacting Public Health Service Act § 2719, which requires group health plans and health insurance issuers to provide notice of appeal processes in a "culturally and linguistically appropriate manner"); Title VI -- 42 U.S.C. § 2000d, *et seq.*; ACA, Section 1557, and 42 U.S.C. § 18116 (Nondiscrimination).

Sec. 155.230(a) *General requirement*

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

HCFANY Comment: Although just referring to "notices," this section appears to apply to notices of actions to be taken by the Exchange that will affect the person to whom the notice is being sent, so we suggest that be made clear. If the notice will not affect all of the members of the household, those whose benefits will continue unchanged should be identified. As notices that potentially touch on multiple family members can quickly become complicated, we recommend a table be used to provide the information and clearly identify the member whose benefits are affected and the nature of the impending change.

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

In order for recipients to take any potential remedial action in the event of a denial or termination of a benefit, it will be critical for the notice to particularize the basis for the action. If information or documentation is lacking, for example, the missing information should be specifically identified and described as necessary for a favorable action. Accordingly, HCFANY urges HHS to require all notices of action to include an individualized statement of the reasons for the action.

Since this section applies to notices of action that will trigger appeal rights, it is a bit difficult to fully comment without seeing the regulations on appeals, which are anticipated to be included in a separate proposed regulation. Nonetheless, we note here that any notice of action that may result in the loss of coverage is so critical that a second notice should be required if the enrollee does not respond to the first notice. Accordingly, HCFANY urges HHS to require that a second notice of action be sent if the action will result in termination of coverage and the enrollee has not responded to the first notice.

Sec. 155.230(b) *Accessibility and readability requirements*

This section of the NPRM states that all "applications, forms and notices" be written in "plain language," provide "meaningful access to limited English proficient individuals," and ensure "effective communication for people with disabilities."

HCFANY Comment: Use of plain language is particularly challenging in notices using health insurance terminology. HCFANY recommends that HHS identify terms that have benefited from consumer testing, or conduct further tests to provide recommendations for the most accessible terms to use in describing the different forms of subsidized coverage. States with multiple public programs should be urged to individualize references to programs, so that notices do not include boiler plate lists of hypothetically applicable programs.

In addition, to assure that ALL written communications follow the required language standards, we suggest that the language be expanded to refer to "applications, forms, notices and any other documents sent by an Exchange." Accordingly, HCFANY urges the NPRM to give guidance as to best practices when using plain language to describe health coverage and expand the regulatory requirement for accessibility and readability to include "any other documents."

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

Rather than just stating that there must be access for LEP individuals, we believe that the final rule should include specific requirements for translating notices and other documents into other languages when thresholds of LEP individuals in the service area of the Exchange are met. We recommend a threshold of 500 LEP individuals or 5% of those eligible to be served by an Exchange, whichever is less. The 5% rule is utilized in both the DOJ/HHS LEP Guidance, as well as in recently revised regulations governing marketing by Medicare Part C & D plans. The 500 comes from an existing Department of Labor regulation. This threshold has been met without complaint by the nearly 20 Medicaid Managed Care plans operating in New York City.

Further, all notices and other documents should be required to contain a "tag line" in a minimum of 15 languages, informing individuals how to obtain copies of the notice in their language or otherwise obtain assistance in their language. Accordingly, HCFANY urges the NPRM to clarify that all notices and other documents must be translated into other languages if a 5% minimum threshold of particular language speakers live in the Exchange's service area; also, require tag lines in at least 15 languages be included at the bottom of all notices, informing non-English speakers of where to obtain assistance in their language.

The Exchange should keep track of non-English speakers and should provide notices in the appropriate language once the Exchange has information that an enrollee or applicant is only fluent in another language. At a minimum, once an LEP individual makes a request for materials in a non-English language, the Exchange should provide all subsequent notices or other documents to the individual in that language. HCFANY urges the NPRM to clarify that notices be provided in the LEP enrollee's language once that enrollee has requested assistance in that language.

The Departments of Health and Human Services, Labor and the Treasury recently published guidance and proposed regulations under the ACA to implement the disclosure for group health plans and health insurance issuers of the summary of benefits and coverage and the uniform glossary. This Exchange NPRM should be consistent with these documents and proposed regulations. Accordingly, HCFANY recommends that the terms used in notices and other documents be the same as those published for disclosure by group health plans and health insurance issuers.

Sec. 155.230(c) *Reevaluation of appropriateness and usability*

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

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

Further, we believe that, in addition to consultation with HHS, the Exchanges should be required to consult with stakeholder representatives, specifically consumers or persons who represent the interests of consumers, in regard to notice language. Accordingly, we urge that HHS approve all Exchange documents for readability and that HHS approve Exchanges' accessibility policies for LEP persons and persons with disabilities. We further urge that HHS require that Exchanges work with stakeholders to review notices for readability and accessibility.

HCFANY recommends that HHS adopt the following recommended amended language for § 155.230. All additions are shown in italics and bold.

(a) *General requirement.* Any notice required to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers, and enrollees ***announcing an action that will impact said person's eligibility for or benefits under a health plan*** must be in writing and include:

(1) The reasons for the intended action;

(2) A citation to or identification of the specific ***law or*** regulation supporting the action;

(3) An explanation of appeal rights, if applicable; and

(4) Contact information for available ***consumer assistance*** resources.

(b) *Accessibility and readability requirements.* All applications, forms, notices ***and other documents (hereinafter, "documents") to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers, and enrollees, or to be published on the Exchange's website for the intention of communicating information to said persons must meet the following requirements***:

(1) ***The documents must be written in plain language.***

(2) ***The documents should use terms consistent with those set forth in the disclosure for group health plans and health insurance issuers of the summary of benefits and coverage and the uniform glossary under the Affordable Care Act published by the Departments of Health and Human Services, Labor and the Treasury.***

(3) ***The Exchange must provide for meaningful access to limited English proficient individuals.***

a. ***Tag lines must be provided on all documents in no less than 15 different languages, informing individuals how to obtain copies of the notice in their language or otherwise obtain assistance in their language.***

b. ***If there are a minimum of 500 persons or 5% of the persons in the service area of the Exchange who are limited English speaking and proficient only in another particular language, the Exchange shall be required to translate notices and other documents into those languages.***

c. Once an LEP individual makes a request for materials in a non-English language, the Exchange should provide all subsequent notices or other documents to the individual in that language.

(4) The Exchange must ensure effective communication for people with disabilities.

(5) All documents must be submitted to HHS for review of readability and must be approved by HHS prior to use. HHS must also review and approve the Exchange's plan for accessibility, both regarding LEP persons and persons with disabilities. The Exchanges must also consult

with stakeholder representatives, specifically consumers or persons who represent the interests of consumers, in regard to document language.

(c) *Reevaluation of appropriateness and usability.* The Exchange must reevaluate the appropriateness and usability ***of documents*** on an annual basis. ***Any changes to documents must be approved by HHS.***

§ 155.240: Payment of Premiums

This section of the NPRM describes the procedures to be used for collecting premium payments.

HCFANY Comment: HCFANY supports the requirement that an Exchange accept payment of an aggregate premium by an employer. HCFANY urges HHS to require that credit card or other payment processing fees should not be imposed upon consumers by the Exchange or carriers.

§ 155.260: Privacy and Security of Information

This section of the NPRM describes the proposed standards for Exchanges to use to maintain consumer privacy and security of information.

HCFANY Comment: HCFANY generally supports this section of the NPRM. We specifically support the provision which imposes a $25,000 fine per person where information is improperly disclosed.

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

§ 155.405: Single Streamlined Applications

This section of the NPRM describes the single streamlined application which must be used by an Exchange to determine eligibility and enrollment.

HCFANY Comment: HCFANY strongly supports the efforts in the NPRM to establish a single streamlined application for eligibility and enrollment of individuals and families into the state Exchanges. HCFANY specifically supports the requirement that Exchange use a single streamlined application for QHPs, subsidies, and public programs and making it available in paper and online versions. We also encourage HHS to add a specific requirement in the final regulation that states

that applicants may not be required to answer questions that are not pertinent to the eligibility and enrollment process. This is especially true because even in well-intentioned states such as New York, additional relatively irrelevant questions (e.g. veteran's status, information about water bills) abound. HCFANY supports maximizing data sharing opportunities, but urges HHS to adopt a provision which ensures that consumers have the election to not participate, and must be allowed to see the information that is shared. HCFANY believes that individuals should be allowed to file an application in person.

Finally, HCFANY agrees with the idea of permitting "someone acting responsibly for an applicant" to file an application on behalf of an individual or family seeking enrollment. *See* §155.405(c)(1)(iii).

§ 155.410: Initial and Annual Open Enrollment Periods

This section of the NPRM describes the rules for initial and annual open enrollment periods when a consumer may seek coverage through a State Exchange.

HCFANY Comment: Having witnessed many health system transformations (e.g. mandatory Medicaid Managed Care, Disaster Relief Medicaid), HCFANY is extremely supportive of the NPRM's effort to have an extended open enrollment period in 2014—in fact, we urge HHS to adopt a longer period of initial enrollment than the five months outlined in the NPRM (October 1, 2013 – February 28, 2014). In addition, HCFANY urges HHS to take this opportunity to urge Exchanges to use "pre-qualification" for enrollment for a period of at least six months in advance of October 1, 2013. HCFANY also agrees with the concept in HHS' memorandum of allowing at least twice-monthly effective dates of coverage or complete flexibility to allow coverage to begin any day for people who forego receipt of advance credits for their first partial month or who are not eligible for advance payments.

HCFANY also urges the NPRM to allow an Exchange to auto-enroll consumers in new QHPs if they receive subsidies and their QHP is closing, but only after extensive efforts to contact the consumer. The consumer should have a 90 day period after that to change plans.

§ 155.420 Special Enrollment Periods

The section of the NPRM describes special enrollment situations.

HCFANY Comment: HCFANY commends HHS for considering the idea of liberalizing its current special enrollment rule which permits special enrollment periods for those who gain dependents through birth, marriage, adoption, or placement in adoption. We strongly urge HHS to

permit States the opportunity to expand this list more broadly (such as situations where an individual gains a dependent through other life events). We would expand the list to include, for example:

- Termination (for any reason) of participation in public health insurance (including Basic Health Plan, Medicaid or SCHIP)
- Aging off of parent's plan
- Pregnant women or children under the age of five
- Change in provider from one plan to another, where continuity of care is medically necessary
- Separation, divorce or annulment
- Death of family member
- Loss of job (voluntary or involuntary)
- Change to new employer that doesn't offer coverage
- Change in residence
- Termination or expiration of COBRA, or where COBRA costs more than 5% of Gross Family Income
- Loss of eligibility for group coverage (e.g. reduction of hours)

In response to HHS' request for comment, HCFANY believes that the special enrollment period should be from 60 days of when the enrollee received notice that they have a special enrollment election option. Likewise, for those who have ESI that does not meet the minimum value requirements, the date of election should derive from when the enrollee receives notice. The date of notification is crucial because we know from the past two years that many employers and COBRA carriers fail to adequately inform individuals of their COBRA election rights (or their rights to federal COBRA subsidies, while they were offered).

Finally HCFANY believes that consumers should be allowed to change tiers of coverage during a special election period (e.g. when a women becomes pregnant).

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

Subpart H describes the functions and standards for states to establish the Small Business Health Options Program (SHOP).

HCFANY Comment: HCFANY is generally supportive of the NPRM. We have two concerns.

First, HCFANY is concerned that the HHS has inappropriately imported unnecessary and duplicative immigration verification rules into the SHOP Exchanges. Employers must already verify an employee's immigration status upon the date of hiring. To reprove an immigrant's status is an unnecessary burden upon employers.

Second, HCFANY agrees that a small employer includes employer groups of up to 100 employees, but does not include sole proprietors or otherwise self-employed individuals who constitute a group of 1 (or any family members that would be included in a family policy). This provision would be inconsistent with current New York State law which includes sole proprietors in our small group market. Obviously, this issue would be eliminated were our individual and small group markets to merge into one market. We believe the categorization of sole proprietors will encourage this to occur. We urge HHS to require states to assist sole proprietors with accessing any available tax credits that they may be eligible for.

Subpart K – Exchange Functions: Certification of Qualified Health Plans

§ 555.1000: Certification Standards for QHPs

This section of the NPRM (§555.1000(c)(1)) provides that Exchanges may certify health insurance issuers if they comply with the minimum certification requirements of subpart C of part 156 of the regulations. Section 555.1000(c)(2) provides an additional basis for denying certification, namely that "making the health plan available is in the interest of qualified individuals and qualified employers," codifying section 1311(e)(1)(B) of the ACA. States are given discretion as to whether to adopt an "any-willing-plan" model, or to implement "active purchasing approaches," including selective contracting or price negotiation.

HCFANY Comment: HCFANY believes that the NPRM should encourage exchanges to play an active purchaser role. At a minimum, the NPRM should clarify that state Exchanges may function as active purchasers and in the "interest of qualified individuals and qualified employers" standard to avoid legal challenges by health insurers. The NPRM should also clarify that Exchanges may specifically engage in selective contracting and engage in price negotiations.

§155.1020: QHP Issuer Rate and benefit information

This section of the NPRM 555.1020(a) provides that state Exchanges must receive justifications for rate increases from QHP issuers "prior to" the implementation of increases, and that the "Exchange must ensure that the QHP issuer has prominently posted the justification on its website as required under §156.210 of this subtitle."

HCFANY Comment: HCFANY believes that the final regulation should require that such notification of premium increases should use the state notice periods of rate increases, in the event that the state time frame is longer than the proposed federal time frame for consumer comment. HCFANY also recommends that the regulations afford the state discretion as to which entity has

the responsibility to monitor whether the QHP has met the web posting requirements in the regulation, subject to HHS approval.

HCFANY believes that the proposed requirement of a "prominent" posting of the justification on the insurer's website under sections 555.1020(a) and 156.210 is not adequate to protect consumers. The regulation should also require that the posting is not "deceptive" or "unfair." New York State reinstituted prior approval of certain health insurance premium rates in the 2010 legislative session. Chapter 107, Laws of 2010. In the summer of 2010, insurers began to seek rate increases under the new law. The State Department of Insurance was forced to write several insurers that the first round of rate increase notices under the law were deficient in several respects, including the making of misleading claims that attributed the rate increases to mandates under the ACA and the state's mental health parity law. An explicit HHS mandate that justifications as to rate increases not be deceptive or unfair will help ensure that consumers and businesses have adequate information to make appropriate decisions as to which health plans to select. Such a requirement will also deter deceptive website notices, given that deceptive notices would then be subject to state consumer fraud and "unfair and deceptive practices" (UDAP) statutes, enforceable by state attorneys general and in many instances, private actions by insured consumers. (Further, an explicit requirement that notices be non-deceptive is particularly important because in New York and other states, compliance with federal statutes or regulations is sometimes a defense to a UDAP action.)

Section 555.1020(b) of the proposed regulations provides that the Exchange must consider rate increases as part of the certification process. HCFANY believes that the regulation should specify that a health insurer's rate increase justification should only be considered to the extent it is reasonable and supported by sound actuarial data that is publicly disclosed. HCFANY has recently reviewed several recent exorbitant rate increase proposals by major health insurers that had absolutely no publicly available justification and/or supporting documentation, and insurers have argued that significant supporting documentation should not be publicly disclosed. Insurers should not be able to advance patently insufficient justifications or those not available to the public to mitigate claims of unreasonable rate increases in seeking certification to participate in the Exchange. Further, we believe that the Exchange should be authorized to accept recommendations as to patterns or practices of excessive or unjustified premium increases from parties other than the state, such as consumer groups.

§ 155.1040: Transparency in Coverage

This section of the NPRM provides that the Exchange must "monitor" whether QHP issuers have made "cost-sharing information available in a timely manner upon the request of an individual as required by § 156.220(d) of this subtitle."

HCFANY Comment: HHS should define "timely manner" in the regulations for those requesting information through means other than the Internet; in our view, two business days would be a reasonable requirement. Absent a specific deadline, it is hard to see how an Exchange could "monitor" whether issuers have met this obligation. HCFANY believes that the requirements as to Exchange monitoring should be also made more specific; perhaps Exchanges should be required to investigate the practices of issuers under this provision on at least an annual basis. Finally, we note that the NPRM explains that Exchanges are authorized to consider the information provided under this section in the certification process under the "interest of the …individuals served by the Exchange" inquiry. We recommend that this statement be incorporated into the text of the regulation to provide more effective guidance to regulators, issuers, and the public.

§ 155.1050: Establishment of Exchange Network Adequacy Standards

This section of the NPRM outlines standards for network adequacy in QHPS.

HCFANY Comment: HCFANY supports inclusion of the additional specific network standards suggested by HHS in the NPRM. We also recommend that QHP issuers be required to include standards to ensure the availability of sufficient providers with the capacity to serve those with limited English proficiency in the service area of the QHP. For each of the primary languages spoken by a substantial number of non-English speakers in the QHP's service are, the QHP should be required to ensure that there are sufficient providers with staff who are fluent in this language, or have ready access to interpretation services.

HCFANY believes that the regulations should specify the types of providers necessary to constitute an adequate network. In particular, we are concerned that networks include sufficient numbers of specialty providers in each geographic region they serve, including providers of reproductive health care and HIV/AIDs treatment. For areas where significant populations exist that are at increased risk for particular illness or conditions (i.e., asthma in polluted urban communities), the network must include a sufficient number of health care providers with the expertise to address these conditions.

In our view, the second factor (i.e., "reasonable proximity of participating providers") should be further delineated. HHS should consider: (1) incorporating the Medicaid standard of at least three primary care physicians that are accessible by no more than a half-hour's trip through public transportation; (2) board certification of provider lists; and (3) appropriate doctor to patient and specialist to patient ratios. As to services other than primary providers, HHS could adopt a numerical standard setting forth the number of providers offering a specific service per population cohort needing that service—similar ratios are used in New York's Medicaid Managed Care

program. Finally, we believe that the first factor (assuring that "services are accessible without unreasonable delay") should also be further delineated in the regulation; we believe that HHS should consider a requirement that enrollees should generally be able to obtain a non-emergency appointment within three weeks, and an emergency appointment without undue delay.

HCFANY supports the inclusion of an additional standard that Exchanges ensure that provider networks provide sufficient access to care for all enrollees, including those in medically underserved areas. Finally, we believe that the regulations should provide that meeting the Exchange's network adequacy standards should be a condition for certification of a QHP by Exchanges.

§ 155.1055: Service Area of a QHP

This section of the NPRM requires Exchanges to have minimum standards to establish and evaluate each the service areas of QHP issuers, with a presumption that service areas are at least the size of one county and sets forth a requirement that the service area defined by the Exchange has been established without regard to racial, ethnic, language and health status related factors or other factors that exclude high cost or medically underserved populations.

HCFANY Comment: While HCFANY generally supports the NPRM, we urge HHS to make it more explicit. HCFANY believes that Exchanges should be required to determine that QHP issuers' provider networks and other service measures provide sufficient access to care and equitable levels of services for all enrollees within the defined service area, including those in medically underserved areas. We are particularly concerned about the provision of inferior services in rural areas and in minority communities within a county or multi-county service area that is as a whole predominated by urban or nonminority populations. In our state, this is a problem both in neighborhoods within New York City and elsewhere in the state; for example, several "upstate" cities in New York are majority white as a whole, but contain neighborhoods where significant numbers of people of color live. Unless addressed by the regulations, issuers would have the incentive to "cherry-pick" healthier or other low-cost enrollees or to target their services to such enrollees.

§ 155.1075: Recertification of QHPs

This section of the NPRM describes the recertification process for QHPs.

HCFANY Comment: HCFANY notes that the NPRM indicates that the recertification process will be "less intensive" than the initial certification process, given that the Exchange will have an established relationship with the issuer. While HCFANY agrees that this will often be the

case, we believe that HHS guidance should reflect the fact that sometimes a more intensive review will be required for certain issuers upon recertification, such as when there is a pattern of lack of compliance with the standards set forth by the Exchange during the initial certification period or the current recertification period.

§ 155.1080: Decertification of QHPs

This section of the NPRM describes the process when an Exchange may decertify a QHP.

HCFANY Comment: Section 155.1080(c) of the NPRM provides that an Exchange may at any time decertify a health plan if the Exchange determines that a QHP issues is no longer in compliance with the general certification criteria outlined in section 155.1000(c). HCFANY is concerned that the certification criteria in section 155.1000(c) alone -- essentially compliance with minimum certification requirements of subpart C of part 156 and evidence that making the health plan available is in the interest of individuals and employers -- may not be explicit enough to address the decertification situation. We recommend that HHS provide examples of improper conduct that would justify decertification, such as the imposition of sanctions by state insurance departments or other state regulatory agencies (like state health departments) or the exchange. HHS may wish to consult standard licensing statutes throughout the nation to arrive at an appropriate list of the grounds for decertification.

Part 156: Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

Subpart C: Qualified Health Plan Minimum Certification Standards

§ 156.200: QHP Issuer Participation Standards

This section of the NPRM describes the standards under which a QHP may operate in an Exchange.

HCFANY Comment: The NPRM (§156.200(b)(4)) proposes that a QHP issuer is in good standing if it has no outstanding "sanctions" imposed by the state's department of insurance. HCFANY believes that this interpretation is too narrow. Other state agencies (such as the Health Department in New York State) play a role in the licensure of insurance companies and/or the regulation of insurer practices. Further, in New York and other states, state attorneys general enforce various requirements applicable to insurance companies, including state UDAP statutes and unfair insurance practices statutes. In some instances, the enforcement process does not involve administrative action but litigation, and injured consumers have the right in some instances to bring

private actions for violations of these and others statutes. Finally, states should have the discretion to examine the practices of the insurer in other states to protect their own residents.

HCFANY thus recommends that, in addition to the existing regulation, which mandates a finding of lack of good standing in the specified instance, the existing interpretation (or regulation) be broadened to provide that Exchanges have the discretion to deem a QHP issuer as not in good standing if: (1) it has outstanding "sanctions" imposed by any agency involved in the licensure of insurance companies and the regulation of insurance in the state, or in an another state in which the conduct impacts on state consumers; or (2) it has outstanding court "sanctions" (whether characterized as injunctive relief, an award of monetary damages, restitution or other sanctions) that are imposed by a court or magistrate as a result of an action brought alleging illegal practices affecting substantial numbers of insurance consumers (individuals or businesses).

HCFANY commends the NPRM (§156.200(e)), which prohibits QHP issuers from discriminating on the basis of color, national origin, disability, age, sex, gender identity or sexual orientation with respect to its QHPs. We urge HHS to include guidance delineating the practices that would come under this prohibition. In particular, we believe the guidance should clarify that practices that have disparate impact on racial minorities, women, and other traditionally excluded groups, including insurance "redlining" of certain neighborhoods or regions would fit under this prohibition. We also believe that HHS should clarify that failure to offer coverage to same sex spouses or partners duly married in states like New York that have adopted marriage equality, civil union, domestic partner or similar laws would constitute prohibited sexual orientation discrimination.

§ 156.210: Submission of QHP Rate and Benefit Information

This section of the NPRM describes how QHPs would submit rate and benefit information to consumers. HCFANY refers HHS to our comments under 155.1020 as to subdivisions (b) and (c) of section 156.210.

HCFANY Comment: HCFANY generally supports the standard suggested in the NPRM mandating that issuers submit a rate justification in the form and manner determined by the Exchange. However, to make state standards effective, we believe HHS should provide minimum standards for rate justifications, and also guidance as to the form of such justifications. As discussed elsewhere in these comments, New York insurers have submitted rate increase requests without any publicly available justifications, or entirely conclusory justifications; in some instances, false or misleading justifications (such as that the need for the increase was due to the costs imposed by the ACA) have been provided to consumers and the State Department of Insurance. Minimum federal mandates coupled with federal guidance will make it more likely that insurers will provide accurate

and informative rate increase justifications. Of course, states should be free to impose more stringent requirements than the federal minimums.

HCFANY also supports federal standards explaining the meaning of the requirement that rate increase justifications should be "prominently" posted on issuer websites. Common sense dictates that the term "prominent" includes a requirement that the justification should be at least in text of the same size as regular explanatory text on the website. Further, rate justifications should be placed on (or prominently linked to) the same page as general interest consumer news (i.e., insurer press releases and discussions of new insurer products and services available to consumers) and also on pages that describe the available health plans to potential subscribers (including employers and individuals). HHS should strongly consider consulting with experts on consumer disclosures and the readability of such disclosures in developing this standard.

§ 156.220: Transparency in Coverage

This section of the NPRM requires certain statutorily mandated information to be disclosed by QHP issuers.

HCFANY Comment: HCFANY urges HHS to mandate that the information presented on the web page be in plain language and that a search function for the services inferred be included so that consumers and businesses may easily make comparisons between health plans or available plan options. In addition, HCFANY believes that the mandated information should be required to be made available to the public on the website, by telephone, and, upon request, in written form. Further, no information that is not mandated by the express language of the ACA is required to be disclosed by the proposed regulation.

HCFANY believes that a number of additional disclosures should be required. First, the proposed requirement that data on the number of claims denied be disclosed (§156.220(a)(5)) should be expanded to require that issuers break down this information by the type of services, such as oncology, cardiology and gynecology; we also recommend that the types of services be listed in the regulation. Such a requirement will enable policymakers to identify patterns of improper conduct that might require remediation. Second, the disenrollment data (§156.220(a)(4)) should be enhanced by a listing of the major reasons for disenrollment, such as dissatisfaction with plan coverage or a poor customer service experience. Third, disenrollment data (§156.220(a)(4)) should be broken down by major categories of enrollees, including by race, gender, ethnicity (minimally, Hispanic status), primary language, disability status, and geographic region, to identify patterns of differential treatment requiring action by policymakers. Fourth, the specific services covered and any major categories of services they do not cover (including abortion, if this is the case) should be disclosed

and required to be placed on the issuer's website to better inform the public in making health care and coverage decisions.

§ 156.225: Marketing of QHPs

This section of the NPRM outlines marketing guidelines for QHPs.

HCFANY Comment: HCFANY commends HHS for requiring QHP issuers to comply with any applicable state law and regulations regarding marketing by health insurance issuers (§156.225(a)). This will enable Exchanges to "ensure that the Exchange considers a QHP's marketing practices in determining whether offering a QHP is in the best interest of consumers," in other words, as part of the certification, recertification and decertification process. HCFANY urges, however, that the regulation clarify that the term "applicable State laws and regulations" includes not just specific statutes and regulations aimed at the insurance industry or health insurance industry, but general state laws concerning marketing such as UDAP statutes that which are in place in the overwhelming majority of states.

HCFANY further urges HHS to add to its regulations a broad prohibition against unfair or deceptive "marketing" practices by all QHP issues and their agents; we recommend that HHS clarify that all unfair or deceptive acts and practices engaged in by issuers and their agents are prohibited, whether or not such acts or practices fit within the definition of marketing. (For example, deceptive billing practices should come under the prohibition, not just practices designed to induce consumers to select or renew their insurance coverage.) We agree with HHS that the enumeration of specific practices would raise the danger that issuers will argue that they have a "safe harbor" from enforcement by state authorities if the act or practice they engage in does not specifically fall under the HHS regulation. However, this can be easily addressed by a statement in the regulation that the unfair or deceptive practices enumerated in the regulation are not intended to be an all-inclusive list, a common practice in UDAP statutes. We also support a prohibition against misrepresentation of the benefits, advantages, conditions and exclusions, limitations of a QHP, as suggested in the NPRM, so long as the "safe harbor" problem is addressed as just discussed. Of course, violations should be fully investigated (with the possibility of decertification) and taken under consideration in the decertification process.

The NPRM seeks comment on how exchanges can monitor QHP issuers' marketing practices to determine whether they have discouraged enrollment of individuals with significant health needs. One method would be to provide that discouraging enrollment of individuals with significant health needs constitutes an unfair or deceptive practice, potentially subjecting such practices to actions by state attorneys general. Further, marketing practices should be the basis for a complaint filed with the Exchange, and a pattern of complaints should be a basis for decertification.

Finally, Exchanges -- perhaps in conjunction with state attorneys general -- could also consider the use of "secret shopper" calls or other undercover methods to determine what information is provided to callers who report to the issuers that they have significant health needs.

§ 156.230: Network Adequacy Standards

This section of the NPRM describes the standards to ensure that QHP issuers maintain up-to-date provider directories.

HCFANY Comments: Provider directories are not only important for current enrollees to access current services, but also to determine whether to select a different plan during the open enrollment period. HCFANY believes that it is reasonable to request that QHP issuers reprint a current version of their provider directories in sufficient quantities to accommodate consumer requests on a monthly basis at a minimum. On the web, however, provider directories should be updated in real time on QHP issuer websites. Failure to meet this standard should be a basis for decertification or other penalties by the exchange or applicable state enforcement authorities.

HCFANY also recommends that the regulations mandate that provider directories be organized by geographic region, languages spoken, and health care specialty.

§ 156.235: Essential Community Providers

This section of the NPRM describes standards relating to essential community providers.

HCFANY Comment: HCFANY agrees with HHS' suggestion that a definition specifying that the QHP issuer "has a sufficient number and geographic distribution of essential community providers to ensure timely access for low-income, medically underserved individuals in its health plan service area," has merit, but is too general. In particular, the regulation should also include a requirement of access for low-income and medically underserved individuals through public transportation in which the time necessary to access the essential community provider is not unreasonable. This is particularly important in rural sections of the nation. Secondly, access should not have to just be adequate for essential community providers as a whole. Instead, the exchange must ensure that low-income and medically underserved individuals have access to an array of specific services that are necessary for effective health outcomes, including women's health services and HIV/AIDs services. Further, whether or not the ACA requires issuers to contract with all essential community health providers, issuers should be required to contract with providers that provide particularly unique and essential services (such as family planning clinics or women's health centers) that would not otherwise be available in each geographic area in a timely fashion or in a reasonable time by public transportation.

§ 156.265: Enrollment Process for Qualified Individuals

This section of the NRPM describes the proposed enrollment process for qualified individuals. HHS has indicated that it intends to issue standards for the content of the enrollment information package, and is considering including in the package an enrollment card, information on how to access care, the summary of benefits and coverage document, as wells as information on how to access the provider directory and drug formulary and how to submit a request for a hard copy of these documents.

HCFANY Comment: HCFANY agrees with the provision of information by a plan as described above. HCFANY also urges HHS to mandate that information on how to file a complaint involving issuer practices and the contact information for any consumer assistance program or ombudsman established pursuant to section 1002 of the ACA that is authorized to assist enrollees in disputes with the issuer be included in the enrollment package.

We recommend that the summary of benefits and coverage document should also clearly specify whether abortion is covered, as the ACA allows issuers to decline to cover this service and this information is clearly material to women's decision as to whether to select a particular plan. The document should also clearly inform individuals and businesses how to switch plans, especially in situations where the plan does not provide coverage for services (like abortion) that are necessary to enrollees.

§ 156.270: Termination of Coverage for Qualified Individuals

This section of the NPRM describes the process for handling individuals whose coverage has been terminated.

HCFANY Comment. HCFANY agrees with HHS' suggestion (§155.430(b)) that a QHP must provide a reason for termination and the termination's effective date should be mandated to be included in any termination notice. We believe that such termination notices should be required to provide the reason for termination in plain language, and that it be mandated that one or more of the specific "termination events" provided for in section 155.430(b) be specifically referenced, along with the cite to the regulation.

The NPRM should further prohibit conclusory statements as to the event or events which form the basis for the decision to terminate the enrollee. HHS should require that factual allegations, at least in summary form, be provided in the notice. (For example, "payments of premiums for coverage of the enrollee have ceased" should be deemed inadequate; the notice should

have to include the last known payment before the payments ceased.) Finally, if the enrollee has previously indicated that English is not his or her primary language, the termination notice should be furnished in both English and the language specified by the enrollee or his or her agent or representative.

HCFANY also urges the NPRM to require the following information in termination notices, including: (1) a telephone number and email address within the company should be provided where more detailed information is available about the termination and where consumers may dispute or obtain an explanation for the termination; (2) information about how to appeal the proposed termination, the deadline for appeal, and (3) the contact information for any consumer assistance or ombudsman program in place under section 1002 of the ACA that is available to assist the enrollee with any dispute over termination. As consumer assistance programs vary from state to state (for example, some programs may be accessible through a statewide toll-free number, and others may have regional telephone numbers), the regulation should provide that the Exchange should determine by regulation the form of such information.

The NPRM (§155.430(c)) provides that QHP issuers must afford enrollees who are recipients of advance payments of the premium tax credit a three-month grace period prior to being terminated from coverage, consistent with ACA section 1412(c)(2)(B)(iv)(II). We do not see the argument for not affording the three-month grace period to those who are not recipients of advance payments, providing that they have previously made at least one's month's premium payment or some other minimum number of premium payments and have therefore signaled their intention to obtain and pay for health coverage. Particularly given the difficult economic circumstances many individuals and businesses find themselves in and the critical importance of maintaining health coverage, cancellation of a health insurance policy because of the missing of a single payment is an unreasonably harsh result; termination could of course push some consumers into bankruptcy if the missing of the payment or payments comes as a time when the consumer faces large medical bills. There is also a possibility of inadvertent error (by the consumer's bank, the consumer or an employer) which is far more likely to be corrected in the case of a three-month grace period, with appropriate notice to the individual consumer or policyholder.

The NPRM (§155.430(e)) requires that QHP issuers provide enrollees with notice of payment delinquency; HHS seeks comment on the potential required elements of this notice. We agree with HHS' suggestion that the total amount of the delinquent payment, the possible date of coverage termination and the payment options should be included; we would add at least a prominent warning that termination of health insurance coverage may result from continued delinquency and the conditions under which termination will occur (for example, failure to make two additional payments after one month's delinquency in the case of those who are recipients of advance payments in the regulation's current form).

§ 156.280: Segregation of Funds for Abortion Services

This Section of the NPRM describes the requirements for QHP coverage of abortion services.

HCFANY Comment: The NPRM should interpret the term "separate payments" in line with standard insurance practices to allow consumers to make multiple payments with one instrument. Section 1303 requires insurance plans that cover non-excepted abortion services to collect separate payments from certain individuals, one for the cost of coverage for non-excepted abortion services and one for the remainder of the premium, and deposit these separate payments in separate accounts. We urge HHS to interpret the term "separate payments" under section 1303 to allow consumers to make the required multiple payments via one instrument—a single credit card charge, electronic transfer, check, or withdrawal—which health care issuers must then deposit into the two required allocation accounts in accordance with the Act.

Section 1303 requires certain individuals who purchase health insurance that includes coverage of non-excepted abortion services to make separate payments, one for the cost of coverage for abortion and one for the remainder of the premium. We urge the Department to clarify that the requirement to make separate payments applies only to those individuals who receive federal subsidies. Section 1303(b)(2)(B) requires the issuer of an insurance plan to collect separate payments from each "enrollee" and hold the payments in separate accounts. We urge OMB and HHS to clarify that separate payments are only required to be made by those who are responsible for paying for coverage, namely subscribers, so as to place the requirement in line with Congressional intent.

We urge the Department to reconcile Section 2718(b), which requires health plans that have a medical loss ratio below the specified limits to provide an annual rebate to each enrollee, and the "special rules" for abortion under section 1303, so as not to inadvertently penalize plans that cover abortion. Specifically, we ask the Department to make clear that costs associated with section 1303 compliance should be excluded from the medical loss ratio calculation.

Finally, the NPRM should specify that an Exchange cannot prohibit plans from participating in the Exchange based solely on the coverage of abortion. Pursuant to section 1311(d)(1), a state must decide whether an existing state agency, a new state agency, or a non-profit entity established by the state will operate its Exchange. The Department should make clear that the operating agency or non-profit must not be permitted to exclude plans on the basis of abortion coverage if the plan otherwise satisfies the benefit requirements of a QHP as defined under sections 1302(b) and 1303 and applicable state law.

§ 156.285: Additional Standards Specific to the SHOP

This section of the NPRM outlines additional standards that apply to the SHOP.

HCFANY Comment: Proposed section 156.285(d)(2) requires all QHP issuers to terminate coverage for all enrollees if a qualified employer chooses to withdraw from participation in the SHOP. HCFANY believes that such termination should be accompanied by a notice to the employees of their alternatives in this situation, including but not limited to the purchasing of individual coverage through the exchange.

§ 156.290: Non-Renewal and Decertification of QHPs

This section of the NPRM outlines the process by which a QHP can leave the Exchange.

HCFANY Comment: Proposed section 156.290(a)(1) requires QHP issuers that propose not to seek recertification to provide notice of this decision prior to the beginning of the recertification process adopted by the exchange pursuant to section 155.1075. However, withdrawal by an issuer may entail significant disruption of the market; as HHS suggests, the exchange may need to add issuers into the exchange to ensure adequate health care alternatives for consumers. There, we recommend that HHS consider mandating that notice be provided at a fixed time earlier than the general date set forth by the exchange for the beginning of the recertification process.

General Comments

Overall, we commend the Department for developing these proposed regulations. We would like to call the Department's attention to two areas that should be more fully addressed: the Basic Health Program, and access to the Exchange for undocumented immigrants.

We recognize that the Department has promulgated a separate set of regulations relating to the Basic Health Program (BHP), and we will comment on those regulations as well. However, we believe that the BHP is a critical piece of the continuum of coverage for low-income consumers that includes the QHPs and affordability programs, and should be more squarely integrated into the Exchange implementation of those programs.

We also commend the Department for not expanding on the ACA's exclusion of undocumented immigrants from Exchange services, but we believe that the regulations should address ways in which an Exchange can serve these members of our communities. New York state has many undocumented residents, and many families in New York and the rest of the country are

mixed immigration status families. New York takes advantage of opportunities to use state funding to serve undocumented immigrants through the Emergency Medicaid and hospital financial assistance programs. The Department should clarify that Exchanges can use both federal and state funds to help undocumented immigrants access programs for which they qualify, to ensure that all residents of a state can learn about and use the health care programs that have been made available to them.

Thank you for considering our comments. If you have any questions, please contact Elisabeth Benjamin at ebenjamin@cssny.org or at (212)614-5461 or Arianne Slagle at aslagle@cssny.org or (212) 614-5541.

Sincerely,

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