



October 24, 2011

The Honorable Kathleen Sebelius, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

RE: Comments on Proposed Rule on Establishment of Exchanges and Qualified Health Plans (CMS-9989-P)

Dear Secretary Sebelius:

We appreciate the opportunity to comment on the proposed rule regarding the establishment of exchanges and Qualified Health Plans that implements the Patient Protection and Affordable Care Act (ACA).

Georgetown University's Center for Children and Families is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. Central to our work is providing research and policy assistance to state administrators and state-based organizations on strategies for covering children and their families through public insurance affordability programs. We also conduct research and analysis to inform federal and state policymakers about issues impacting children and families in health care reform and to improve Medicaid and CHIP, particularly around streamlining enrollment and renewal systems.

The Georgetown University Center for Children and Families (CCF) is providing comments on the exchange establishment standards included in the proposed 45 CFR Parts 155 and 156 in hopes of ensuring that the unique needs of children and adolescents are addressed by various aspects of the Affordable Care Act as it continues to unfold. Specifically, CCF is providing comments on the following sections knowing that these particular areas will impact the access that children and adolescents will have to insurance products sold through state based exchanges. We urge the Department of Health and Human Services to consider the following suggestions to ensure that children's needs are met.

Areas of concern and comment:

- General Standards Related to the Establishment of an Exchange
- Consumer Assistance Tools
- Navigator Program Standards
- General Standards for Exchange Notices
- Payment of Premiums
- Enrollment Periods

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Network Adequacy  
Stand-alone Dental Plans  
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We believe that, in many of these areas, more specific guidance is needed to ensure that the needs of children, families, and all consumers are met.

### **§155.110 Entities eligible to carry out exchange functions.**

**The majority of exchange board members should be “consumer representatives.”** The preamble of the NPRM states that a majority of exchange governing boards should represent consumers’ interests (page 27). The text of the proposed rule at 155.110(c)(3), however, holds only that a majority of the board should NOT have a conflict of interest. We recommend that you conform the language of the actual rule to the explanation in the preamble. To this end, the final rule should specifically require that to meet the requirement that a governing board structure “represents consumer interests,” (155.110(c)(3)), a state must ensure that its governing board structure is comprised of a majority of “consumer representatives.” The rule also should provide a definition of “consumer representative” that makes it clear that simply lacking a conflict of interest is not sufficient qualification.

- **Recommendation:** Amend 155.110(c)(3) to require that governing board membership include a majority of “consumer representatives” defined as someone who is 1) him/herself a customer of an exchange plan directly or on behalf of a family member (or reasonably expected to be once exchanges are operational), or 2) a representative of a non-profit organization that advocates for or represents constituencies served by the exchange, including but not limited to organizations comprised of or representing all consumers, children, children with special health care needs, low-income individuals, immigrant families, or those with a certain disease or condition.
- **Alternative Recommendation:** Amend 155.110(c)(3) to require that governing board membership include a plurality of consumer representatives, as defined above.

**Members of exchange boards should not have a conflict of interest.** Exchanges are intended to foster competition to achieve their goals of greater coverage, lower prices, and higher quality. They are designed to be fair marketplaces with strong consumer protections. It will undercut the credibility and effectiveness of exchanges if they are governed by individuals who have a conflict of interest. Of particular concern is that insurers and those affiliated with the insurance industry may have incentives to protect their market share and profits at the expense of quality and efficiency.

- **Recommendation:** Specify at 155.110(c) that individuals with a conflict of interest may not serve on an exchange board. A conflict of interest should be defined to include a financial interest in a business affected by the exchange’s decision-making or a position

of governance with such a business. The definition should also specifically bar individuals affiliated with the insurance industry, a related trade association, or a contract with the state from serving on the board.<sup>1</sup>

**§155.110(f) HHS should review governance structures through Exchange Plans.** The NPRM requests comment on the frequency of HHS review of exchanges' accountability and governance structures. At 155.110, the regulations establish that states must submit and HHS must approve an Exchange Plan. Exchanges' accountability and governance structures should be described in their state Exchange Plan and HHS should review the structures when the Plan is filed and at any time it is amended.

- **Recommendation:** Require that states describe exchange accountability and governance structures in their Exchange plans. HHS should review the structures when the Plans are filed and any time they are amended to ensure that consumers' interests are paramount.

#### **§155.205 Required consumer assistance tools and programs of an exchange.**

**Require that exchanges conduct a consumer assistance needs assessment.** The NPRM includes a list of consumer assistance tools identified in the statute, but it offers no principles or guidance on the role that exchanges should play in ensuring that consumers have the tools they need to find and use affordable coverage. Of particular concern from a children's perspective is that many families with children will be navigating multiple sources of coverage, and will need cohesive, tailored consumer assistance to ensure each family member connects to appropriate coverage and/or care.

- **Recommendation:** Each state should be required to outline in its Exchange Plan the steps it has taken to conduct an assessment of consumer assistance needs within the state; the range of consumer assistance tools and programs that it will use in light of those needs (including required tools); and a mechanism for evaluating the effectiveness of state consumer assistance efforts over time.

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<sup>1</sup> Maryland's exchange law provides an important example of language that reflects these concepts and we encourage consideration of it when developing a definition of "conflict of interest." It precludes a member of the exchange board or staff of the exchange from having an affiliation with (i) a carrier, an insurance producer, a third-party administrator, a managed care organization, or any other person contracting directly with the exchange; or (ii) a trade association of carriers, insurance producers, third-party administrators, or managed care organizations; or (iii) any other association of entities in a position to contract directly with the exchange. It defines an "affiliation" as (i) a financial interest, as defined in § 15-102 of the state government article; (ii) a position of governance, including membership on a board of directors, regardless of compensation; (iii) a relationship through which compensation, as defined in § 15-102 of the state government article, is received; or (iv) a relationship for the provision of services as a regulated lobbyist, as defined in § 15-102 of the state government article. See [§ 15-102 of the state government article of the Maryland Code](#).

**Ensure that call centers meet the needs of call consumers.** The exchange call center should serve as a full-function customer service center providing all consumers with direct access to assistance through the exchange. The preamble of the NPRM suggests a variety of functions for these call centers that should be codified. Call centers should be required, as a condition of the exchange approval process, to establish a quality assurance program that evaluates the quality of services rendered through the call-center and develops strategies to improve assistance as needed.

- **Recommendation:** Specify in §155.205(a) that the call center must:
  - Operate outside normal business hours;
  - Include multi-lingual and culturally competent staff;
  - Maintain confidentiality and notify consumers of the safeguards for privacy of personally-identifiable information
  - Provide assistance to consumers and businesses on the full range of issues that affect whether people can enroll in coverage or secure care, including but not limited to:
    - The types of QHPs offered in the exchange;
    - The premiums, benefits, cost-sharing and quality ratings associated with the QHPs offered;
    - Information on who is eligible and for what and provide confidential basic screening for eligibility prior to application.
    - The application and renewal process for enrollment in coverage through the exchange, Medicaid, CHIP and BHP (if applicable).
    - Referrals to navigators, state health insurance ombudsman programs and other consumer assistance programs.
    - Referrals to other sources of health care for those who are not eligible for coverage through the exchange, Medicaid, CHIP or the BHP (if applicable).
  - Facilitate applications over the phone and assist consumers with issues encountered in using the exchange website.

**§155.205(b) Internet website.** The exchange website will be a primary source of information for families and interaction between exchanges, individuals, small business consumers, navigators and other stakeholders. The preamble seeks comment on whether exchange websites should be required to include “my account” and “third party access” functions. We strongly support adding those requirements in the final rule.

**Require states to establish a personal account function.** An optional “personal account” (or “my account”) through which individuals can start and stop the application or enrollment process, add or delete information, report changes, receive notices, check their benefits, renew coverage and control access to their personal information is critical, especially for families with children and others who need maximum flexibility to apply outside of work hours and potentially over the course of a multi-day period given competing demands on their time. The inclusion of “personal accounts” at the option of applicants and enrollees not only enhances the potential of the website to serve the needs of applicants and enrollees but

also maximizes administrative efficiency by allowing applicants and enrollees to manage their own information and record changes in their circumstances, such as the birth of a new child.

- **Recommendation:** Specify at §155.205(b) that applicants and enrollees must have the ability, at their option, to establish and maintain a personal account.
- **Recommendation:** Specify at §155.205(b) that individuals must be able to establish controls over how their personal information can be accessed and used.

**Provide navigators and other application assistors with “third party access.”** The exchange website should provide functionality for navigators and other appropriate third parties (such as Medicaid or CHIP eligibility workers) to assess real-time information and assist applicants and enrollees in all aspects of the application, enrollment and account management processes. In light of the sensitivity of health, income and citizenship/immigration information, it is critical that such functionality be accompanied by appropriate privacy, security and audit controls.

- **Recommendation:** Specify at §155.205(b) that the website must be designed to provide navigators and other appropriate third party facilitators with direct access to the website and functionality that allows them to assist applicants and enrollees in applying for and managing their benefits. The final rule should specify the third party access functionality must:
  - Include appropriate privacy, security and audit controls.
  - Provide reporting capabilities for navigators and other assistors to aggregate their assistance activities and outcomes, as well as provide the exchange with reports it needs to assess their performance.

**§155.205(d) Consumer Assistance Function.** The term “consumer assistance” should be more clearly defined. The proposed rule specifies that an exchange must have a “consumer assistance function,” but fails to define this term. We recommend that the final rule provide more detail on what is meant by a “consumer assistance function,” and, in particular, that it make clear that consumer assistance includes providing assistance with all aspects of the health care enrollment and delivery system.

- **Recommendation:** §155.205(d) should specify that an exchange’s consumer assistance function must ensure that exchange-eligible individuals and/or participants can secure confidential assistance with eligibility, enrollment and renewal requirements and processes for Medicaid, CHIP, BHP (if applicable) and both subsidized and unsubsidized coverage in QHPs; premiums and cost-sharing; benefits and coverage limits; how to access services; QHP quality ratings and transparency of coverage measures; how to file a complaint, grievance or appeal; and information and referral for persons ineligible for the Exchange, Medicaid, CHIP or the BHP (if applicable).

**§155.205(e) Outreach and education.** The rule should provide more guidance on what constitutes adequate “Outreach and education.” The nation’s successful efforts to increase the enrollment of eligible uninsured children in coverage offers important lessons on what constitutes the minimum essential components of effective outreach and education. The final rule should incorporate these lessons and provide more specificity on outreach and education requirements. In particular, to maximize the effectiveness of outreach and education in the exchange, outreach should broadly promote the value of coverage to uninsured individuals, families and small businesses (rather than promoting a single coverage option); target specific hard-to-reach populations; and be coordinated among the various entities, including navigators that are conducting outreach and education activities. States should ensure that efforts among all entities conducting outreach and education, including navigators, are coordinated and convey accessible, accurate, appropriate, fair and impartial information.

- **Recommendation:** Amend § 155.205(e) to require exchanges to conduct outreach and education activities to broadly promote access to coverage for the uninsured (without regard to a specific coverage option) and encourage participation.
- **Recommendation:** Amend § 155.205(e) to require exchanges to conduct outreach and education activities that target underserved populations; specific hard-to-reach populations (e.g., adolescents, rural residents); those who experience health disparities due to low literacy, race, color, national origin, or disability including mental illnesses and substance abuse disorders; and other groups identified by a state as experiencing low rates of coverage.
- **Recommendation:** Amend § 155.205(e) to require that exchanges coordinate their outreach and education activities with navigators and other entities conducting such activities and ensure that all information is accessible, accurate, appropriate, fair and impartial.

### **§155.210 Navigator program standards.**

**Ensure that the diverse needs of individuals and small businesses in accessing coverage options are fully met by strengthening the navigator program.**

**§155.210 (a) Exchanges should be required to conduct a needs assessment for the purpose of designing and implementing their navigator programs.** Navigators will provide vital assistance to both individuals and small businesses in accessing affordable health coverage options. To ensure that the navigator program is sufficiently robust, we recommend that states be required to conduct a needs assessment and design their navigator programs accordingly. All consumers needing assistance should be able to find a navigator who is geographically accessible and has the expertise to meet their needs,

including those of people with disabilities, with low literacy or limited-English proficiency, families with mixed immigration status and other hard-to-reach populations. Given the importance and complexity of the navigator role in making the ACA work as intended, we recommend that the final rule require states to establish a training program for navigators and build in ongoing evaluation and improvement.

- **Recommendation:** §155.210(a) General Requirements should be amended to require exchanges to:
  1. Conduct a needs assessment of the individuals and small businesses to be served through the exchanges to determine the number and types of entities to be selected as navigators;
  2. Establish a navigator training curriculum and certification requirements; and
  3. Set quality standards and develop mechanisms to assess navigator performance and accountability in meeting the standards.

The proposed rule requires exchanges to engage at least two types of qualified entities to serve as navigators and requests comment on whether one of those should be community or consumer-oriented nonprofit organizations.

- **Recommendation:** The number and types of qualified entities should be determined based on the needs assessment discussed above. However, no less than two types should be required and one of those types **must** be community or consumer-oriented nonprofit organizations.

**§155.210(b) Navigators should not be subject to traditional licensure requirements.**

Navigators do not solicit, negotiate or sell insurance and, therefore, should not be subject to the traditional licensure requirements for brokers and agents.

- **Recommendation:** Amend §155.210(b)(1)(iii) to expressly state that exchanges may not require navigators, as a condition of participation in the navigator program, to “be licensed as an insurance broker or agent.”

**§155.210(c) Prohibitions on navigator conduct should be more clearly defined with regard to relationships with health insurance issuers outside of exchanges.** The risk of conflicts of interest are too great to allow navigators to receive direct or indirect consideration from issuers of health plans inside OR outside the exchanges.

- **Recommendation:** Amend §155.210(c)(2) to add an explicit prohibition that navigators may not receive direct or indirect consideration from health insurance issuers outside the exchanges.

**§155.210(d) Clarify that one of the duties of navigators in exchanges is to assist consumers in applying for premium tax credits and cost-sharing reductions.**

An essential duty for navigators will be to assist individuals in applying for premium tax credits and cost-sharing reductions, as well as Medicaid, CHIP and BHP (if applicable).

- **Recommendation:** Add additional duties to navigators at §155.210(d)(3) – Assist individuals in applying for financial assistance through Medicaid, CHIP, BHP (if applicable) and advance payments of the premium tax credit and cost-sharing reductions for QHPs, and facilitate enrollment in Medicaid, CHIP, BHP or QHPs.

**Ensuring linguistic and cultural competency.** The final regulation should clarify the linguistic and cultural competency requirements for navigators. This is an especially important issue for children – over 35%<sup>2</sup> of the remaining uninsured children in the United States resided in mixed immigration status families where such competencies are particularly needed.

- **Recommendation:** Navigators must be subject to the same nondiscrimination requirements as exchanges with regard to translating materials and providing oral assistance to LEP individuals. We recommend that vital documents be translated when there is a threshold of 500 LEP individuals or 5% of those eligible to be served by a navigator, whichever is less. Navigators should be required to provide taglines in at least 15 languages that inform LEP applicants and enrollees of how to access language services. With regard to oral interpretation, navigators must ensure that oral assistance – through competent interpreters or bilingual staff – is provided to *all* LEP applicants and enrollees, regardless of whether thresholds for translating documents are met. If navigators provide information through a website, we also suggest navigators include translated materials, taglines, and information on how consumers can obtain oral language services.

**§155.230 General standards for exchange notices.**

**Ensure consumer participation in annual reviews of notices and allow consumers to select preferred method of communication.** The proposed regulations requiring notices should be strengthened in the following ways.

- **Recommendation:** At §155.230(a), the requirement that notices be in writing should be clarified to include electronic notices if an applicant or enrollee chooses to receive notices in this manner. Applicants and enrollees should be able to specify their preferred method of communication (i.e. via mail, e-mail or text messages).

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<sup>2</sup> [http://www.princeton.edu/futureofchildren/publications/figures-tables/figure\\_show.xml?fid=247](http://www.princeton.edu/futureofchildren/publications/figures-tables/figure_show.xml?fid=247)



- **Recommendation:** §155.230(a) should be amended to require exchange or QHPs to send more than a single notice when communicating action that the applicant or enrollee must take to avoid a negative consequence including but not limited to loss of coverage and denial of enrollment.
- **Recommendation:** §155.230(c) should be amended to require that when conducting annual and periodic review of applications, forms and notices, exchanges must gather input directly from consumers and/or consumer advocacy groups.

### **§155.240 Payment of premiums.**

**To facilitate the payment of premiums, consumers should have multiple options for making premium payments.**

- **Recommendation:** §155.240(a) should be amended to require that exchanges and QHPs must provide consumers with multiple methods for paying premiums in person (at exchange offices or select retail sites), online, over the phone or via the mail through cash, check, debit, credit or automatic electronic funds transfers.

### **§155.405 Single streamlined application.**

**The single streamlined application should be made available through common forms of available technology.** The concept of no-wrong door (meaning access to all coverage options is assured through a single point of entry) and providing multiple application tools (online, over the phone, by mail and in person) are important to maximize enrollment of individuals and families. The regulations should ensure that the use of technology is enabled for access through mobile devices.

- **Recommendation:** Require at §155.405(c)(2)(i) that the internet portal be accessible by common browsers and operating systems, as well as mobile devices.
- **Recommendation:** Amend §155.405(c)(2)(ii) to include by telephone through a call center or via a smart phone application.

Additionally, in response to the NPRM request for comments, we strongly support an in-person application option for those who need personalized assistance and are more comfortable with obtaining such assistance from an official exchange office.

- **Recommendation:** Require at §155.405(c)(2)(iv) that exchanges must provide individualized assistance for applicants to complete the application in person at an exchange office (not just “file” an application). Such an office could be a Medicaid agency or other similar existing office.

In response to the request for comment, we strongly endorse a prohibition against requiring persons completing applications to answer questions that are not pertinent to the eligibility and enrollment process related to those for whom coverage is sought. In instances where exchanges are seeking information that is useful, but not required for eligibility or enrollment (e.g., an email address), it is important that exchanges be required to make it clear that such information is optional.

- **Recommendation:** Amend §155.405(a) to require exchanges to use only the standard single streamlined application designed by HHS to determine eligibility and to prohibit requiring applicants, or persons completing application forms on behalf of applicants, from answering questions that are not pertinent to the eligibility and enrollment of those applying for coverage for themselves. Exchanges must be required to accompany any request for helpful but not required information with a communication that the information is optional and that failure to provide it will not affect the eligibility determination.
- **Recommendation:** Amend §155.405(b) to specifically note that any alternative application cannot require information that is not necessary to the eligibility and enrollment of those applying for coverage. If a state wants to request additional information, it must make clear that it is optional to provide answers and that not doing so will not adversely affect a family's opportunities to secure coverage.

#### **§155.410 Initial and annual open enrollment periods.**

**The initial enrollment periods should be extended in order to maximize enrollment opportunities. Coverage effective dates should be flexible to avoid gaps in coverage.** Millions of people will be seeking assistance and securing coverage through new systems that inevitably will need retooling as experience unfolds. To ensure that all individuals, families and small businesses have time to obtain information, consider their options, and successfully complete the eligibility and enrollment process, it is critical to maximize the initial enrollment period. It should be extended past the tax filing deadline of April 15 to give applicants the opportunity to use the latest tax information. It is also important to devise a schedule that is easy to remember and minimizes the potential for gaps in coverage.

- **Recommendation:** Amend §155.410(b) to establish that the initial open enrollment period begins October 1, 2013 and extends through April 30, 2014.

The proposed effective dates for coverage at §155.410(c) for applications received on or after the 23<sup>rd</sup> of a month will result in gaps in coverage that should be avoided. Even though premium tax credits only apply for full month coverage, applicants should be given the option for immediate coverage at the full unsubsidized cost.

- **Recommendation:** Amend §155.410(c) to allow for an effective date of coverage that allows the applicant to choose an effective date starting with the date of application (generally how Medicaid works) or on the first day of an upcoming month.

### **§155.420 Special enrollment periods.**

#### **Effective dates of coverage during special enrollment periods should be flexible.**

**Every effort should be made to avoid any gaps in coverage.** Just as the NPRM provisions dealing with termination propose ending coverage to coincide with the beginning of new minimum coverage, the “effective start date of coverage” in a QHP should coincide with the effective end date of other coverage.

- **Recommendation:** The effective start date of coverage during a special enrollment period should be tailored to the circumstances of the triggering event in order to provide continuous coverage and avoid coverage gaps (i.e. birth is effective on birth date, effective date aligns with loss of other minimum coverage, etc.)
- **Alternative Recommendation:** The effective start date of coverage during a special enrollment period should begin on the 1<sup>st</sup> day of the 1<sup>st</sup> month following the application or upon the effective end date of other coverage, whichever is later.

**Allow an exception for moving from one coverage level to another for pregnant women.** The preamble requests comment on allowing an exception to the proposed limits on moving from one coverage level to a new one during a special enrollment period for pregnant women covered by catastrophic plans. We strongly support this provision to encourage access to cost-effective prenatal services that reduce the potential for low-weight and premature births.

- **Recommendation:** Amend §155.420(d)(1) to clarify that loss of minimum essential coverage includes the loss of coverage through Medicaid, CHIP, or BHP if applicable.
- **Recommendation:** Amend §155.420(f) to provide an exception for pregnant women covered by a catastrophic plan to move to a different plan. The final regulations should not only allow such a change during a special enrollment period, but also should be added as a specific qualifying event that triggers a special enrollment period.

#### **Remove restrictions on changing plan levels during special enrollment periods.**

Generally speaking, events that trigger special enrollment periods are not related to changes in health status. Therefore, these events would not necessarily lead to adverse selection as much as they are reason for individuals and families to reassess their need for and ability to pay for coverage. We recommend removal of the prohibition on movement between plan levels during special enrollment periods.

- **Recommendation:** Strike §155.420(f).
- **Alternative Recommendation:** Retain the exception for movement between plans proposed in the NPRM with the additional exception for pregnant women covered in a catastrophic plan as noted above.

### **§155.430 Termination of coverage.**

**Termination of coverage must be made in a timely manner.** Requests for voluntary terminations should be processed in real or near-real time so as not to incur additional financial liability on behalf of the individual or family.

- **Recommendation:** Amend §155.430(d) to establish that the reasonable notice be one business day.

### **§155.1050 Network adequacy standards.**

**Exchanges must be required to take an active role in monitoring the adequacy of the QHP networks, and exchange standards for assessing the adequacy of QHP networks should be subject to HHS approval.**

**Exchanges should establish standards for assessing the adequacy of QHP networks, subject to HHS approval.** The NPRM requests comment on whether the exchanges should establish specific standards under which QHP issuers would be required to maintain aspects of network adequacy specified in the preamble. We believe that the exchanges should establish such standards, subject to HHS approval. In developing their standards for network adequacy, exchanges should be required to ascertain the needs of the population served through the consumer needs assessment recommended above (related to consumer assistance), which should also determine the health status/conditions of the population served. The application of rigorous standards should result in a robust panel of pediatric providers, including primary care providers; a complete range of medical and surgical specialists (including pediatric subspecialists); habilitative/rehabilitative therapy providers (e.g., occupational, speech and physical therapists); mental health and substance abuse professionals; and vision and dental care providers, including those that specialize in serving children.

- **Recommendation:** As suggested in the preamble, amend §155.1050 to require that the exchanges establish specific standards under which QHP issuers would be required to maintain the following: (1) sufficient numbers and types of providers to assure that services are accessible without unreasonable delay; (2) arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of

enrollees, including a reasonable proximity and accessibility of providers accepting new patients; (3) an ongoing monitoring process to ensure sufficiency of the network for enrollees; and (4) a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner. Require that the exchanges define the terms “unreasonable delay,” “reasonable proximity,” and “timely manner.”

- **Alternative recommendation:** Exchanges should require that QHPs adhere to the standards set forth in the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act, at a minimum.

**Exchanges should be required to monitor the adequacy of QHP networks based on the standards they establish and QHPs should be required to publicly disclose data related to their network adequacy.** In addition to QHPs monitoring their own network adequacy, exchanges should be required to do so as well, pursuant to the standards they establish (see above). Exchanges could monitor QHP networks through data submitted by the QHPs and perhaps through enrollee surveys. To provide competitive incentives to improve their networks, QHPs should be required to publicly disclose data related to their network adequacy, such as wait times for appointments.

- **Recommendation:** Amend §155.1050 to require that exchanges be required to monitor QHP network adequacy according to the standards developed by the exchanges. Require QHPs to publicly disclose data related to their network adequacy (e.g., wait time for appointments).

**Exchange standards for judging network adequacy must be approved by HHS.** To ensure that exchanges are evaluating network adequacy through appropriate standards, we suggest that HHS require exchanges to submit their evaluation tool for approval by HHS. In order to establish appropriate standards for evaluating the utility of the exchanges’ standards, we recommend that HHS convene a panel of experts and/or adopt current data, industry standards, best practices and existing regulatory/statutory language on the subject, such as the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act.

### **§155.1065 Stand-alone dental plans.**

This section takes on the difficult task of accommodating several provisions of the statute that are not perfectly aligned:

- Section 1302(b)(1)(J), which sets out the categories of essential health benefits, requires that QHPs provide pediatric oral health care. However, there is no requirement that QHPs provide oral health care for adults.

- Section 1311(d)(2)(B)(ii) requires that exchanges allow issuers of stand-alone dental benefits to offer their plans in the exchanges either separately or in conjunction with a QHP as long as the plan provides pediatric dental benefits as required under section 1302.
- Section 1302(a)(4)(F) states that if a stand-alone dental plan is offered in an exchange, another plan offered through the exchange “shall not fail to be treated” as a QHP solely because the plan does not offer a pediatric dental benefit.
- Section 36B(b)(E) of the Internal Revenue Code states that the portion of the premiums payable to a stand-alone dental plan allocable to the pediatric benefit should be treated as a premium for the QHP.

As interpreted in the proposed rule, we are concerned that individuals and families seeking coverage through exchanges will not be able to access the pediatric dental essential benefit due to a lack of choice and affordability. While we assume that many QHP issuers will offer pediatric dental coverage as a part of the QHP benefits, that may not be the case in all exchanges. If pediatric benefits are only available through a stand-alone family dental plan, families will be able to obtain the required pediatric benefits by purchasing such a family plan. Solely offering a family dental benefit, either as a part of a QHP or as a stand-alone dental plan, would make it much more expensive for consumers to obtain pediatric dental coverage because premium tax credits could not be used towards the adult dental benefit, as adult dental coverage is not included in the essential benefits package. To ensure the intent of the statute to provide all children with essential oral health care is carried out, we recommend that the final rule requires each exchange to offer at least one option that allows families to obtain pediatric benefits without having to purchase a dental plan for adults in the family. This could be accomplished through requiring a child-only dental benefit, either through a QHP or as a stand-alone plan, at every coverage level. This will ensure that pediatric dental coverage is financially accessible for low- and middle-income families, even when a family dental benefit is too expensive. If coverage cannot be offered at every coverage level, at a minimum, it is essential that exchange offer at least one child-only dental benefit, either as a part of a QHP or as a stand-alone plan, at the silver level, since premium tax credits are calculated for coverage at this level.

We also acknowledge the concern voiced in the preamble of the proposed rule regarding the allocation of premium tax credits for dental benefits. We understand that it may be difficult to allocate advanced payments of premium tax credits and calculate the actuarial value when stand-alone dental plans segment the essential benefits. However, we believe it is essential and required by the statute that pediatric dental coverage, whether offered through a QHP or as a stand-alone plan, can be paid for with a premium tax credit. Families should not have to spend more money to obtain pediatric dental benefits for their children when pediatric dental coverage is a part of the essential benefits package.

- **Recommendation:** Each exchange should offer at least one child-only dental benefit, either as a part of a QHP or as a stand-alone plan, at every coverage level in the exchange. At a minimum, the final rule should require that each exchange must offer at least one child-only dental benefit, either as a part of a QHP or as a stand-alone plan, at the silver level. In addition, consumers must be able to pay for the pediatric dental essential benefit with premium tax credits.

**§155.1065(c) Certification standards.** We also believe that it is crucial to require stand-alone dental plans to comply with adequate certification requirements and consumer protections. In the preamble of the proposed rule, HHS states: “We are considering interpreting this provision such that an Exchange may require issuers of stand-alone dental plans to comply with any QHP certification requirements and consumer protections that the Exchange determines to be relevant and necessary.” We urge HHS to require stand-alone dental plans to comply with the certification requirements and consumer protections required for QHPs. We believe that there must be a federal minimum of certification standards and consumer protections for the stand-alone dental plans. Pediatric dental coverage is a required essential benefit that should be valued as an important component of the health coverage offered through the exchanges, and should therefore be subject to QHP certification requirements and consumer protections.

- **Recommendation:** Stand-alone dental plans within exchanges must abide by the relevant certification requirements and consumer protections of QHPs. As discussed in the preamble of the proposed rule, these standards include: quality reporting, transparency measures, summary of coverage information, provider network standards, and standards regarding consumers’ experiences in comparing and purchasing plans. In addition, stand-alone dental plans should abide by the following consumer protections that will be required to be provided by QHPs, including: the right to an external appeals process, coverage of dental preventive services at no cost, coverage of children up to age 26, and prohibitions against exclusions based on pre-existing conditions and unfair rescissions of coverage.

### **§156.255 Rating Variation**

**To facilitate the appropriate calculation of premium tax credits, the regulations should establish that exchanges must require qualified health plans to offer coverage in each of a limited number of rating categories. Further, the regulations should ensure that child and children only plans are available to families and priced appropriately by establishing appropriate age rating rules.**

The proposed section 156.255(c) allows insurers to combine the four proposed rating categories. For example, an issuer could choose to offer only two categories of coverage—single and family—rather than offering coverage to each of the four categories discretely.

Other issuers might choose to offer more rating categories. Allowing issuers in an exchange to offer different numbers of rating categories makes the calculation of the benchmark premium as proposed by the IRS impractical and unnecessarily complicated. As currently proposed, it would be possible for many issuers in an exchange to offer only individual and family coverage and only a single issuer to offer coverage in the one-adult with children or two adult rating categories. A family composed of one adult and two children could enroll in either a plan offered in the family category or in the one-adult with children category. It is unclear which plan would be considered the second-lowest cost silver plan for the purposes of computing premium tax credits for such a family—is it the second-lowest cost silver plan in the family category or in the one-adult with children category? What if there is only one plan offered in the one-adult with children category? To facilitate the identification of the benchmark plan (and assure meaningful competition among qualified health plans), each exchange must establish a set of rating categories that all participating issuers make use of.

- **Recommendation:** Require exchanges to establish a limited number of rating categories and require qualified health plans to offer coverage in each of the categories.

At §156.200(c)(2), the proposed regulations require that each QHP must be offered as a child-only plan for those under age 21. Child-only plans are required by the Affordable Care Act and must be available to meet the needs of families in which parents are ineligible for exchange coverage, reside apart from their children, or for another reason obtain coverage separately for one or more of their children. Section 156.255(c) describes rating categories that must be covered. Child-only plans are not mentioned among these categories and it is unclear where child-only plans fit into them. The regulations should clarify the availability of appropriately priced child- and children-only plans.

Since age rating rules are not included in the NPRM, it is difficult to determine how the categories established in §156.255(c) would interact with age rate bands. Appropriate age rate bands would help ensure that premiums are set at the right level—one that takes into account expected costs for children, not for adults who are more expensive to cover. As in the Pre-Existing Condition Insurance Plan, QHPs should have an age band for children. While the PCIP age band covers those age 0-18, the QHP band should align with the requirements for child only plans and cover those up to age 21. With such an age band, the individual rating category could be appropriately priced for a single child and the family rating category could be appropriately priced for a policy to cover multiple children in the same family. An age band for those under age 21 would not affect the allowable rating variation among adults because section 1201 of the Affordable Care Act specifies that the three to one age rating ratio applies only to adults.

- **Recommendation:** Establish age rating rules that allow plans in the existing categories to be priced for child enrollees.