



VIA ELECTRONIC SUBMISSION (www.regulations.gov)

December 22, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9944-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Notice of Proposed Rulemaking CMS-9944-P

Dear Sir/Madam,

Thank you for the opportunity to comment on the HHS Notice of Benefit and Payment Parameters for 2016, CMS-9944-P, (hereinafter referred to as the “NPRM” or “proposed rule”).

The Center for Children and Families is based at Georgetown University’s Health Policy Institute with the mission of improving access to health care coverage among the nation’s low- and moderate-income children and families. As such, we have a long history of conducting analysis, research and advocacy on issues relating to enrollment in all insurance affordability programs, including Medicaid and CHIP, as well as qualified health plans (QHPs).

We understand that the 2016 benefit and payment parameter rules will not apply until the final rule (NPRM CMS-9944-P) is promulgated. Thus, we hope you find useful our comments and recommendations on the sections of the NPRM that directly impact consumers. Under separate cover, we have submitted jointly with other child-focused organizations comments on sections of the proposal that address the essential health benefits.

G. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

§155.205 Consumer Assistance Tools and Programs of an Exchange

We support the proposed regulation requiring QHP issuers, and agents and brokers to provide oral interpretation services in at least 150 languages utilizing an over-the-phone interpreting agency (OPI). We believe this is important movement towards providing meaningful access to Marketplace coverage to individuals with limited English proficiency (LEP). Title VI of the Civil Rights Act of 1964 prohibits any recipient of federal funds from

discriminating on the basis of race, color or national origin, this includes discrimination based on LEP. Furthermore, section 1557 of the Affordable Care Act also prohibits discrimination under Title I of the ACA and any program administered by a federal agency. This means QHP issuers and agent and brokers, operating in state-based marketplaces or the federally facilitated marketplaces, must have clear plans and services in place to meet the language needs of consumers with LEP. Providing telephonic language services in at least 150 languages is a good start.

Many OPI companies exist but not all have interpreters who have been trained and are competent to interpret in the healthcare arena. There is significant specialized terminology involved in the activities of insurers, agents and brokers that differ from specialized terminology used in legal settings, community interpreter settings, and other settings. It is thus important not only that these entities engage an OPI company but specifically that they contract with one that will be competent to provide interpreting for the specific types of interactions that will be needed. The California Endowment commissioned a report a number of years ago which could be helpful – [*How to Choose and Use a Language Agency: A Guide for Health and Social Service Providers Who Wish to Contract with Language Agencies.*](#)

RECOMMENDATION: HHS should emphasize that this requirement does not limit or abrogate requirements under Title VI of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. It must be clear that this provision sets a floor but not a ceiling on providing language services. In addition, to ensure no individual is discriminated against, these entities should be required to develop language access plans that describe how they will serve consumers whose needs go beyond this language floor.

Further, we recommend that HHS provide guidance on how to select a competent OPI company. Best practices for ensuring competent oral interpretation may be taken from the Certification Commission for Healthcare Interpreters (CCHI)¹ and the National Board of Certification for Medical Interpreters,² both of which use standards established by the National Council on Interpreting in Health Care.³

¹ Certification Commission for Healthcare Interpreters, <http://www.healthcareinterpretercertification.org>.

² The National Board of Certification for Medical Interpreters, *Certified Medical Interpreter Candidate Handbook 2013–2014*, <https://www.certifiedmedicalinterpreters.org/sites/default/files/national-board-candidate-handbook-2013.pdf> (last accessed Sept. 17, 2013).

³ National Council on Interpreting in Health Care, *National Standards of Practice for Interpreters in Health Care*, <http://www.ncihc.org/assets/documents/NCIHC%20National%20Standards%20of%20Practice.pdf>.

Additional guidance and best practices are provided in Standards 5 and 7 of the enhanced National CLAS Standards,⁴ as well as the HHS LEP Guidance.

The proposed rule does not extend the requirement to provide oral interpretation in at least 150 languages to navigators and non-navigators. The preamble expresses concern that imposing the requirement may be cost-prohibitive for some small, not-for-profit agencies and discourage them from serving as navigators and non-navigators. To the greatest extent possible, these groups should strive to hire skilled, bi- and multi-lingual staff to meet the most significant language needs of the communities they serve. Additionally, these entities should be required to provide meaningful access to their services by providing oral language interpretation. This can be accomplished in a variety of ways. CCIIO could set up a contract with a language line and assign access codes that would allow navigators and non-navigator personnel to use the service. By having one contract, CCIIO could negotiate a lesser per-minute fee. Alternatively, CCIIO could allow navigators and non-navigator personnel to use the Marketplace call center's language line. The final rule should ensure that navigators and non-navigators do not reject or delay providing assistance when their personnel cannot meet the language needs of a consumer with LEP.

RECOMMENDATION: CCIIO should contract with language services for navigators and non-navigator personnel to use. Minimally, CCIIO should require navigators to describe the language needs of their service area and present a viable plan for addressing language needs that meet specific demographic criteria (i.e., a percentage of population).

§155.335 Annual Eligibility Redetermination

We appreciate HHS' recognition of the potential negative impact of auto-enrolling QHP enrollees in the same plan. However, the proposed solution creates a different set of issues. At the same time, we think there should be significant improvements to the current process that incorporate an updated eligibility determination and well-crafted notices and outreach designed to maximize the number of people who actively select a plan each year.

We recognize that premiums may change significantly from year to year, and that plans that are most competitively priced in one year may not continue to be the most competitively priced in the next. These premium shifts could result in changes in the benchmark plan and premium credit amounts, which may result in people having to pay significantly more to stay in their current plan.

While enrollees should always be encouraged to update their projected income for the upcoming year, the FFM should automatically update APTCs based on the new benchmark, age rating differences, and updated federal poverty guidelines before sending renewal notices. This would give enrollees better information to make a judgment about plan

⁴ Office of Minority Health, U.S. Dep't of Health & Human Servs., *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice* (2013).

selection at renewal. As currently structured, individuals may keep their current APTC level but when there is a new lower-cost benchmark, their APTC is higher than it should be. In these cases, individuals who take no action may not only pay more for coverage, they may have a higher APTC than they should and as a result will have to pay back excess PTCs.

RECOMMENDATION: Update APTC and CSR eligibility based on the new FPL levels, age rating adjustments, and the cost of the benchmark plan prior to issuing renewal notices.

Auto-enrollment in lowest cost plan. The proposal to allow enrollees to select a default enrollment into a low-cost plan inappropriately places bases plan selection on one criterion: premium cost. Doing so ignores other key factors in selecting a plan, including out-of-pocket costs, provider networks, and drug formularies. An individual who chooses default enrollment into a low-cost plan could pay lower premiums, but may have higher deductibles, co-payments or co-insurance, and/or out-of-pocket limits, and end up paying more for care. Furthermore, there are likely to be significant changes in the health insurance marketplace from year to year. Thus, people who choose this option could lose access to their current provider network, or end up enrolled into plans with different drug formularies or other differences in benefits.

We acknowledge there should be a default process for auto-renewing people who do not actively return to the Marketplace to make plan choices during open enrollment. However, giving people the choice of being defaulted into a low-cost plan a year ahead of time does not address the critical need to develop effective ways to encourage consumers to play an active role in evaluating their plan choices each year. Additionally communicating the impact of making such a choice a year in advance would be difficult and result in a premature decision that does not adequately match their circumstances a year later. Instead, HHS should develop the technology that enables the FFM to recommend plans with similar features as an enrollee's current plan but are lower cost. Consumers may feel more compelled to shop for new plans if they were presented with such relevant information.

RECOMMENDATION: Do not automatically re-enroll consumers into the lowest premium plan as proposed. Instead, provide updated eligibility determinations and additional information to consumers before automatic re-enrollment into their existing plan.

We also recommend that HHS improve the language of notices to enrollees. We believe that the notices developed for the 2015 open enrollment period were vague and confusing, and future notices need to more effectively convey the importance of returning to the Marketplace to make plan choices and the consequences of not doing so. And as noted, in the future, the renewal process should provide people with notice of their updated eligibility determination as set forth in the original rule at 45 CFR §155.335.

Hierarchy for auto-enrolling people when their current plan is no longer offered.

The HHS proposal to give individuals an option to be auto-enrolled into a low-cost plan suggests that the FFM is able to implement alternative hierarchies for auto-enrollment. In

light of this, HHS should revisit the hierarchy it set out for auto-enrolling people into other coverage when their qualified health plan (QHP) is no longer offered in the Marketplace for the following plan year.

We disagree with the process for determining a new QHP for individuals whose QHP is no longer offered in the Marketplace. We are particularly concerned about how the priority order for auto-enrolling individuals into a new QHP would affect those who are eligible for APTCs and cost sharing reductions (CSRs). Under the proposed rule, individuals who are eligible for premium tax credits could potentially be auto-enrolled into a non-Marketplace plan, which means they would no longer be eligible for premium tax credits. Similarly, individuals who are eligible for CSRs could be auto-enrolled into a non-Silver-level plan, which would mean they are no longer eligible for CSRs.

While we understand that people still have the opportunity to switch plans during open enrollment, the goal of the priority order the rule proposes should be for the Marketplace to establish an auto-enrollment process by which individuals do not have to take action in order to maintain the benefits (i.e. APTCs and CSRs) for which they are eligible. As such, we recommend that individuals who are CSR-eligible only be auto-enrolled into a Silver plan in the marketplace (including one offered by another issuer, if necessary), and that individuals who are APTC-eligible only be auto-enrolled into a Marketplace plan (including a plan offered by another issuer, if the previous issuer is no longer offering a Marketplace plan).

RECOMMENDATION: When a consumer's existing plan is no longer available, the new plan into which he or she is auto-enrolled should preserve eligibility for APTCs and CSRs.

§155.420 Special Enrollment Periods

We support extending a special enrollment period (SEP) to residents of states that have not adopted the Medicaid expansion, which will allow people to promptly enroll in coverage through the Marketplace when they experience changes in household size or income that make them newly eligible for APTCs. We read the language of the regulation, which refers specifically to "changes in household income" to also include changes in household composition or size because these would also affect a household's income-eligibility level. HHS should clarify that this is the case. This proposed SEP will help ensure more low-income people with changes during the year are able to receive the subsidies they are entitled to under the Affordable Care Act without having to wait for the next open enrollment period.

RECOMMENDATION: Adopt the proposal to allow an SEP for residents of states that have not adopted the Medicaid expansion and clarify that the SEP is available when household income **as a percent of the federal poverty level** changes.

We also support the proposal to allow for advance availability of a 60-day special enrollment period for people experiencing certain triggering events, including the loss of other minimum essential coverage, loss of Medicaid pregnancy-related coverage, or a permanent move. Being able to adjust coverage ahead of time is critical to helping people experiencing certain life events to avoid gaps in coverage. HHS is proposing to wait until 2016 to make the advance SEP available to people making a permanent move. We urge the agency to instead allow people making permanent moves during 2015 to access a special enrollment period in advance. The current language of the regulation at (d)(7), “The qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move” would appear to permit to allow people such advance access to an SEP. In our work with people assisting consumers, we have been made aware of situations where the lack of advance access to the SEP resulted in gaps in coverage, which are particularly concerning for people with chronic health conditions.

RECOMMENDATION: Allow an SEP for people making a permanent move in 2015 up to 60 days in advance and 60 days following the move.

We support the addition of special enrollment periods in cases when people experience a death or divorce outside of the regular open enrollment period. We agree that a death or divorce, similar to a birth or a marriage, is a significant event that warrants giving individuals and families an opportunity to enroll in or change their health insurance coverage. However, the proposed regulations extend the death and divorce special enrollment period *only to people* who are already enrolled in a qualified health plan. This is inadequate. We urge HHS to establish a broader special enrollment period targeting people who experience a change in income or tax household that makes them newly eligible for advance premium tax credits.

While the proposed SEPs for death and divorce, along with the new SEP for people formerly in the Medicaid coverage gap, improve access to advance premium tax credits and exchange coverage, they are insufficient. Important groups of individuals will still be left out, such as people who are separated but still married during open enrollment but then divorce during the benefit year. The financial picture of the individual members of such a couple would look very different during open enrollment — when they are technically still married and their incomes must be considered together — compared to after open enrollment is over, when the couple’s divorce is final, and both people may become newly eligible for subsidies. Under the proposed regulations, such people could get a special enrollment period only if they were already enrolled in a qualified health plan, which may have been too expensive prior to the divorce, or if there is a loss of minimum essential coverage, such as when one member of the couple received health benefits through the employer of the former spouse. Moreover, we have been told that someone who was living apart from her spouse and knew she would be divorced during the year would be considered married at the time she applied. Therefore, she would have to include her husband on the application. In many cases, her husband’s income, which was not available to her, would make her ineligible. Once she got divorced, she could apply as single but she would need an SEP in order to access a qualified health plan and receive APTCs.

RECOMMENDATION: To address such situations, the final regulations should include within 155.420(d)(6) an additional SEP for the situation when: “A qualified individual or his or her dependent has a change in income, tax household composition, or tax household size resulting in a determination that he or she is newly eligible for advance payments of the premium tax credit.”

For 2015, we also recommend extending an enrollment opportunity so that people who discover they owe a penalty for lacking health coverage during 2014 may enroll in 2015 coverage outside of open enrollment. Many people are unaware of the law’s requirement to have minimum essential coverage or to pay a penalty and do not realize they could receive substantial financial help in obtaining coverage by applying for an advance premium tax credit. Tax filing season will greatly increase awareness of both the penalties and the subsidies, but many people will file their taxes after the close of regular open enrollment in the exchanges and will be unable to obtain coverage for 2015. An enrollment period running through April 15 would allow people who discover they will owe a penalty in 2015 if they fail to secure coverage the opportunity to correct this problem and, if they are eligible, to get help paying for premiums and cost-sharing charges through the Marketplace.

RECOMMENDATION: Provide an SEP to individuals who are required to pay a tax penalty for being uninsured. Alternatively, in future years, consider extending the open enrollment period through April 15.

§156.250 Meaningful Access to Qualified Health Plan Information

We support the proposal requiring QHPs to provide all information that is critical for obtaining health insurance coverage or access to health care services through the QHP, including applications, forms, and notices, to qualified individuals, applicants, qualified employers, qualified employees, and enrollees in accordance with the standards described in §155.205(c). The preamble also requested comment on appropriate translation guidelines that entities serving the Marketplaces should adhere to when translating important documents. We feel strongly that uniform guidelines should be provided to entities serving Marketplace consumers so that they can use them to ensure they are meeting the needs of LEP consumers in areas they serve. We believe that all entities serving Marketplace consumers should translate vital documents into any language spoken by 5% or 500 of the individuals in the entity’s service area.

The 5%/500 thresholds are already employed in other federal agency policy guidance, with some programs and agencies employing even lower thresholds.⁵ HHS LEP Guidance

⁵ U.S. Dep’t of Labor, Style and Format of Summary Plan Description, 29 C.F.R. § 2520.102-2(c)(2) (2012); Supplemental Nutrition Assistance Program (SNAP), 7 C.F.R. § 272.4(b)(2)(i); U.S. Housing and Urban Development, Final Guidance to Receiving Federal Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 72 Fed. Reg. 2732, at 2753.

currently uses a 5% and 1,000 person “safe harbor” threshold,⁶ which leaves out millions of limited English proficient individuals. As an example, when applying the 500 threshold to service areas measured by counties (which may not be the applicable service area for many of the entities covered by this proposed regulation), 1,324 counties in the United States have populations of 500 or more limited English proficient individuals speaking at least one single language, as compared to only 987 counties with populations of 1,000 or more limited English proficient individuals.⁷ A 5 percent and 500-numeric threshold better ensures that the intent and statutory requirements to provide linguistically appropriate services will be met.

The service area may differ depending on the entity. For example, an insurer’s service area may spread throughout a state and should include both potential applicants and enrollees. A navigator’s service area may be more targeted within a city or county and should include all individuals who may be seeking the navigator’s services. Service areas relevant for the application of the thresholds should be entity-specific, encompassing the geographic area where persons *eligible to be served or likely to be directly or significantly affected* by the entity’s program or activity are located. Where no service area has previously been approved, an entity may self-identify the service area, subject to showing that the service area does not discriminatorily exclude certain populations. Documentation of how the self-identifying determination was made and what data was used. As discussed in the HHS LEP Guidance, recipients should determine their service areas based on their actual experiences with LEP encounters as well as demographic data on the languages spoken by those who are not proficient in English.⁸ HHS should consider equipping recipients with data driven maps that show estimates of eligible individuals with LEP for each service area as well as their approximate location.

RECOMMENDATION: Require entities serving Marketplaces to translate vital documents into any language spoken by 5% or 500 of the individuals in the entity’s service area.

It is also critical that translation be done by competent translators. HHS should advise covered entities to use only competent interpreters to translate all documents. Because all documents provided by providers and program administrators tend to have some consequence on the perceptions and actions of people who receive them, it is important to ensure that individuals do not receive erroneous information about available services.

Additional language access can be achieved by including taglines on all documents by those organizations covered by this regulation. The taglines should be in multiple languages noting that free interpretation services are available in all languages and providing the appropriate phone number and instructions on accessing the language service.

⁶ HHS LEP Guidance, 68 Fed. Reg. at 47,319.

⁷ Migration Policy Institute analysis of American Community Survey Data, 2007–2011 (on file with NHeLP). It is noted that some language populations not comprising of 1,000 LEP individuals may still comprise 5% of the population.

⁸ HHS LEP Guidance, 68 Fed. Reg. at 47,314.

We also note that on documents providing vital information such as eligibility determination notices and termination notices, it is extremely important to use customized taglines that adequately represent the importance to call for language assistance because the content of the notice is vital. For example, a generic tagline that says something like “If you or someone you’re helping has questions, call XXX-XXX-XXXX for language assistance...” is insufficient to convey the need to act, particularly on notices that require action such as payments or termination of coverage. We strongly recommend that entities produce notice-specific taglines that identify the type of notice. If notice-specific taglines are not possible, we suggest CCIIO require using the following tagline:

“IMPORTANT: This notice is time sensitive and may impact your eligibility for health insurance. You can get an interpreter at no cost to help you understand this notice. To get an interpreter or to ask about written information in (your language), call XXX-XXX-XXXX.”

We also ask that HHS recommend placement of taglines to ensure they are not buried on the last page of notices where they likely will go unnoticed by LEP consumers who are unlikely to review multiple pages of an English notice. Taglines should be prominent, up-front, and can even be added to the envelope in which materials are sent.

RECOMMENDATION: Ensure competent translation and include taglines that prominently convey the importance of notices.

§156.130 Cost-Sharing Requirements

We support the clarification that non-calendar year plans subject to the cost-sharing requirements must apply an annual limitation on cost sharing for 12 months (even if this does not align with the calendar year), to ensure that an enrollee is only required to accumulate cost sharing toward one annual limit per 12-month period. We support the clarification that issuers are not required but do have the option of counting out-of-network cost-sharing charges toward the annual limitation on cost sharing.

We also support the clarification in the preamble that the individual limit on annual out-of-pocket costs must apply whether a person is in an individual or family plan. The methodology for how annual out-of-pocket costs accrue — specifically whether deductibles and out-of-pocket maximums accrue on an “aggregate” or “embedded” basis — is an important difference between qualified health plans that is not easy for families to determine or understand. Requiring insurers to ensure that no member of a family exceeds the individual out-of-pocket maximum is a step toward greater consistency in protections for consumers who are enrolled in plans other than self-only plans. HHS should also clarify that a parallel protection applies for people who are subject to a reduced annual limit on out-of-pocket costs because they are in a cost-sharing reduction plan.

RECOMMENDATION: Adopt the clarifications on accrual of cost-sharing spending toward cost-sharing limitations.

§156.145 Determination of Minimum Value

We agree that the statutory language for the minimum value requirement fully supports including a requirement that plans include certain critical benefits. While large-group and self-insured employer plans are not required to cover all of the essential health benefits, those plans seeking to provide minimum value coverage should have to satisfy certain basic minimum standards regarding the benefits they do cover. It is particularly critical to ensure there are not major gaps in the benefits of minimum-value employer plans because workers offered such plans (as well as their family members) are barred from accessing federal subsidies through a Marketplace, as long as the minimum-value plan meets the law's affordability test. HHS requests comment on how to test whether an employer plan's coverage of critical benefits is in fact "substantial." In general, coverage should track with what is "typical," or what is provided by a majority of employer-sponsored plans.

RECOMMENDATION: Adopt the proposed language ensuring that employer-sponsored plans seeking to meet the minimum-value standard must both meet the 60 percent quantitative standard and include "substantial coverage of inpatient hospital services and physician services."

§156.220 Transparency in Coverage

Public access to valuable information should not be delayed any further. Information including data on enrollment and disenrollment, the number of claims denials, claims payment policies, and data on cost-sharing and payments with respect to any out-of-network coverage are critical to improving public understanding about the insurance coverage and access to care available through qualified health plans. Data related to claims payment policies, denials, and out-of-network claims and related enrollee expenses should be readily available from issuers' explanation of benefits (EOB) forms. The collection of data on out-of-network claims would provide consumers with important information about the reliability of a health plan's provider network and could also be a starting point for developing better measures of and oversight of health plan network adequacy. We also recommend collecting information about appeals of claims denials, as part of the requirement for QHP issuers to submit information about enrollee rights. HHS should collect data such as how many (and what proportion of total) claims are denied, how many denied claims are appealed, how many first level appeals of denied claims are upheld vs. overturned, how many first level appeals proceed to external review, and how many of those are upheld vs. overturned. This effort could be coordinated with any state-level collection of claims-denial data that may already be occurring.

RECOMMENDATION: Collect and display publicly the required information listed in §156.220 as soon as possible.

§156.420 Plan Variations

We support the proposal to require QHP issuers to provide a Summary of Benefits and Coverage (SBC) reflecting the cost-sharing charges associated with their CSR plan

variations. This is essential to SBCs meeting the goal of helping all enrollees — including those receiving cost-sharing reductions — understand what they will pay when using covered benefits. Since the proposal would require issuers to provide these SBCs by the open enrollment period for the 2016 benefit year, we urge HHS to ensure that the CSR SBCs are made available to the public on Marketplace websites and issuer websites during the same open enrollment period.

RECOMMENDATION: Require Summaries of Benefits and Coverage to be available for all CSR plan variations.

§156.425 Changes in Eligibility for CSRs

We support requiring QHP issuers making a plan change in accordance with §156.425(a) to provide an SBC to consumers reflecting the cost-sharing charges in the new plan variation within 7 days of receiving notification of such a change from the Exchange. When this occurs, QHP issuers should also be required to provide consumers with a notice explaining the change, why it is occurring, and how any cost-sharing amounts the consumer has already paid during the benefit year will be applied to the deductible and out-of-pocket limit of the new plan variation consistent with the requirements at §156.425(b). HHS should require such a notice and create a model notice that would communicate this information as clearly and simply as possible to individuals and families.

RECOMMENDATION: Adopt the proposal to provide an SBC within 7 days of a plan change.

Thank you for consideration of these comments and recommendations. If you have questions, please contact Tricia Brooks, at pab62@georgetown.edu or 202-365-9148.

Respectfully submitted,
Georgetown University Children for Children and Families