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October 31, 2011

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

Re: Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans

Dear Dr. Berwick:

AARP is pleased to provide comments on the proposed rule on “Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans.” As part of efforts to reform our health care system, AARP supports innovative ways to provide access to affordable, quality care. The Exchanges is one of a number of initiatives in the Patient Protection and Affordable Care Act (ACA) to improve access to affordable, quality care. AARP believes these provisions can promote more cost-effective care, improve pricing transparency, and increase health insurance companies’ accountability for quality health care. AARP supports the establishment of exchanges; however, we have some concerns and questions regarding several provisions included in the proposed rule.

Key issues

AARP appreciates the challenges of ensuring that residents of all states will have access to a fully functioning Exchange marketplace by the initial open enrollment period. Our comments on the proposed rules are guided by the principles listed below, but also our belief that Exchanges can be a critical component of the ACA’s comprehensive approach to enhancing the value of our health care dollar in public programs and the private sector through the transformation of health care delivery.

Establish minimum, national standards.

The Department of Health and Human Service (HHS) has worked hard to provide flexibility given the differences among states and their interest in creating an Exchange. Some flexibility may be necessary, but by January 2014 all consumers should receive the full benefits of the ACA with the same protections and assurances, regardless of whether they live in an area with a state exchange, a partnership exchange or a federally facilitated exchange. HHS should assure that exchanges have sound governance structures, serve the individual and small group consumers' interests, are free of conflicts of interest, and are transparent and accountable to the public. They must have the authority necessary to carry out the role of improving the marketplace for those in the individual and small group market and assuring that people can access financial assistance for which they qualify.

Focus on value

HHS should foster the creation of exchanges that focus on making high quality, affordable coverage options available for individuals, families and small businesses. This means that exchanges should focus on the public interest when certifying qualified health plans.

Ensure consumer engagement

The regulations require that the exchange governing body must represent consumer interests overall and not be dominated by those with conflicts of interest. Ongoing consultation of consumers through open and transparent public meetings can provide valuable input and feedback on the work of the exchange. Consumer interests must also be represented on the governing board.

Consumers will need access to information, resources, and assistance about the coverage available to access Qualified Health Plans and other public health coverage options. Given the diversity of the target population, exchanges will need to be ready with clear, effective consumer information, tools and assistance. Exchanges will need to involve a range of community organizations to reach the various target audiences.

Authority and accountability

HHS will confer the authority to carry out the responsibilities of the exchange on state, federal, and partnership exchanges. Regardless of the form of the exchange, they must be accountable to HHS and the public.

Comments
Subpart B –Standards Related to the Establishment of Exchanges
§155.100 Establishment of a State Exchange

The establishment and operation of Exchanges is a critical element of extending access to coverage under the ACA. The Exchanges are the mechanism for facilitating access to QHPs and subsidies that will help make coverage affordable. AARP does not underestimate the challenges that are involved with getting an Exchange established and fully operational in all states in time for the initial open enrollment period (October 2013).

It is a core protection of §1321 of the ACA that if a state does not elect to establish an Exchange, the federal government will operate the exchange in that state. AARP is aware that HHS is working with states, and has expressed a preference for states to operate their own Exchanges within the framework set forth in the ACA and subsequent regulations. AARP recognizes that there are states that have not elected to create an Exchange. The proposed rule does not address how HHS is moving forward with the work necessary to have operational Exchanges in place in such states in time for the October 2013 initial open enrollment period. AARP also realizes that there are states who are taking necessary steps to establish an exchange, but need the assistance of the federal government to have it fully operational. The information released in the PowerPoint presentation dated September 19, 2011, outlines HHS' current thinking about partnership Exchanges. The document provides a general outline of options it is providing states as they determine what, if any, role they want to play in establishing an Exchange to serve their residents. As stated in the preamble, the needs of each state will vary and as a result there will need to be flexibility provided to states that choose this option. However, the partnership option outlined in the PowerPoint presentation would not address those needs. Also, the manner in which the partnership option is described in the preamble seems to include an element that would encourage states to become fully-operational exchanges. AARP appreciates HHS' initial proposal for the partnership option; however, we believe that there needs to be significant clarification provided by HHS regarding roles and responsibilities for the states as well as the federal government. We advise HHS to release technical guidance with a comment period to provide clarity on the partnership model described in the preamble of the NPRM. Additionally, we believe that HHS, in designing the partnership models, needs to keep in mind that, like state-based exchanges, no one model will suit each state and therefore the structure of this option needs to have flexibility for the varying needs of the states. HHS should assure that where it is partnering with a state, the Exchange's function does not suffer. AARP believes that the terms of the partnership should be incorporated in the Exchange plan, so that they will be transparent and subject to public comment.

§155.105 Approval of a State Exchange

If an Exchange is unprepared to assume some of the operational tasks for the initial open enrollment period, the proposed rule provides flexibility by allowing for conditional approval of an Exchange Plan. AARP supports giving states the opportunity to work in good faith to establish an Exchange to serve their residents, but that support presumes HHS is actively monitoring and overseeing Exchange planning and innovation grants implementation. HHS needs to clarify the terms under which it will provide conditional approval to state Exchanges. When granting conditional approval, AARP urges HHS to identify clear goals and timetables the state must meet that identify progress towards a state Exchange becoming fully operational. We expect HHS to have a plan and actively monitor the progress that states with conditional approval are making. AARP believes that HHS should establish a deadline by which a state that is given conditional approval must be fully operational. We believe this date should be prior to the initial open enrollment period. HHS should develop a plan and process for states that fail to complete their goals by the start of the initial open enrollment period.

Various business functions need to be well developed to provide consumers with a simple process by which to obtain quality, affordable health coverage. AARP believes that the agency needs to further clarify the definition of operational readiness. We believe that some functions not directly tied to a consumer's selection of and enrollment in a QHP, such as certifying individuals exempt from the coverage requirement, may not have to be ready by the initial enrollment period. If a state cannot demonstrate operational readiness on the functions necessary to support the initial open enrollment approval, HHS should be prepared to establish a federally-facilitated Exchange, or a partnership if appropriate. Alternatives such as conditional approval and the opportunity to elect to operate an Exchange after 2014 provide pathways for states that are not ready with all required functions to continue to move forward. Meanwhile, residents of states without an approved Exchange will depend on HHS to directly or indirectly perform required Exchange functions.

AARP supports the establishment of a review process for Exchange Plans that is similar to Medicaid and CHIP. As with Medicaid and CHIP, AARP believes that the rules should require each Exchange to document a public comment process – including what comments were made and how the Exchange responded to them. If changes are made to the plan after submission to the federal government, Exchanges should be required to seek additional public comment and document the public input. The Exchange's plans should be posted on the internet where the public can review them. The proposed 90-day period for review and approval should allow for at least 30 days for public comment, particularly if HHS has requested and received additional information.

AARP fully supports the requirement that a State must notify HHS before making significant changes to the Exchange plan, and that HHS must review and approve any such changes before they are implemented. We believe that the rule should define "significant change" and suggest using Medicaid's requirements as guidance.

We urge HHS to provide a template that assures that plans address all the functions of the Exchange as well as how they are to be addressed and performed. We believe this will help the states make sure they have all the necessary functions in place to be fully operation by the initial open enrollment period. In addition, this template would be useful to the federal government in assessing a state's level of progress.

§155.106 Election to Operate an Exchange after 2014.

AARP is pleased to see the rule anticipates transitions when a state either starts or ceases to operate an Exchange after 2014. In situations where the responsibility for Exchange operations shifts from HHS to the State or vice versa, it will be important that the transition appear seamless to the consumer. We also believe that standards for the transition plan should specifically address the consumer impact and the steps that will be undertaken so that the change is transparent to the consumer.

§155.110 Entities Eligible to Carry Out Exchange Functions

The proposal would require an Exchange to have and make publicly available a set of principles that include ethics, conflict of interest standards, accountability, and transparency standards, and disclosure of financial interest. It is our belief that HHS needs to be explicit with the states on how they will comply with the transparency requirement. AARP believes that the rule should include conflict of interest requirements for entities contracted to perform functions that are the responsibility of the Exchange. Preventing conflicts of interest builds public confidence and trust, provides an ethical standard, and is sound business practice.

AARP fully endorses the requirements that the Exchange have an accountability structure, including a formal, publicly adopted charter or by-laws to ensure transparency of the board structure, regular public meetings with advance notice of meetings, opportunities to comment, and the ability of the public to observe and comment on Exchange policies and procedures. AARP also supports the provision requiring that a majority of the voting representatives on the governing body represent consumers. By structuring the governing body in this manner, consumers' needs are more likely to be addressed appropriately. While providers can be patient advocates, and make important contributions to improving the quality and value of the health care system, they also have competing interests as reflected by their offering products and plans through the Exchange. AARP suggests that provider representation should be included in the categories of representatives that cannot comprise a voting majority of the governing body. Further, the HHS approval process should include a review of the governing board’s voting membership.

The interests of the Exchange's target population should always be paramount in board decision making. Experience in areas identified -- such as benefits administration, health plan purchasing, and the uninsured -- also brings value to decision-making and governance. AARP believes that there should be a strong consumer presence on the Exchange governance structure and urges the standard to give preference to requiring at least one or two consumer representatives on the board in order to better achieve the goal of the Exchange – providing consumers with quality, affordable coverage choices and better leverage in the marketplace.

The financial disclosure requirements should be strengthened. Members of the board should not have a direct financial interest in Board decisions. Specifically, AARP supports a standard that members of the board not be employed by or a consultant to a member of the Board of Directors, or otherwise a representative of or lobbyists for an entity in the business of, or potentially in the business of, selling items or services of significant value to the Exchange. This could include but not be limited to carriers or insurers that provide coverage of health benefits, producers, vendors and health care providers selling services directly to the Exchange. Consumers and employers whose only interest is to purchase products from the Exchange should not be defined as having a conflicting financial interest. At a minimum, the proposed standard for implementing procedures for disclosure of financial interests by members of the Exchange board or governance structure should require that those with a financial interest, or whose family members have a financial interest in a matter before the Exchange, be required to remove themselves from discussion and voting on matters in which they have a financial interest. HHS may want to look at the model of MedPAC or PCORI disclosure rules, and should require that states explicitly show how they are satisfying the transparency and disclosure requirements.

AARP recommends that any change in the accountability structure and/or bylaws should be considered a significant change in the Exchange Plan and subject to HHS review. Validated complaints that an Exchange is not following its structure and principles should also generate a review if not addressed by appropriate state regulators. Absent either of these triggering events, HHS should have an ongoing review process in each state of the Exchange's accountability structure and governance.

§155.130 Stakeholder Consultation

AARP is strongly supportive of the requirement for regular and ongoing consultation with stakeholders. The identified list encompasses a wide range of interests and perspectives and ensures that stakeholders precluded from voting representation because of conflicting interests have an appropriate avenue for meaningful participation.

§155.140 Establishment of a Regional or Subsidiary Exchange

AARP understands the rationale for the option of creating regional and/or subsidiary Exchanges given existing demographics of certain areas and existing health insurance market areas. Similarly, small population states may see a regional Exchange as an opportunity to build on the advantages of a larger risk pool. We are concerned, however, that consumer protections potentially could be compromised where regional or subsidiary Exchanges are created if the states in which regional Exchanges operate do not have similar rules governing their individual and small group markets and their Exchanges. This would create inequities between those plans in the Exchange and those in the outside market, possibly leading to adverse selection against the Exchange. AARP urges HHS to develop a process for identifying differences in the individual and small group market rules and consumer protections across the states that are participating in the proposed regional Exchange. If differences exist that would undermine the consumer protections of those buying coverage through the regional Exchange or would likely undermine the Exchange due to adverse selection, AARP believes that the Secretary should withhold approval of such Exchange until the issues are resolved.

§155.160 Financial Support for Continued Operation

AARP believes that in determining the method for supporting the Exchange, the governing body needs to assess the effect of fees or assessments on premiums. If a state chooses to implement user fees as a source of revenue, AARP urges the agency to require states to limit assessments to once a year and also to structure the assessments so that they are built into the premium quoted at enrollment.

User fees should also be structured to preclude any differences between the cost of plans offered in the Exchange and those offered outside the Exchange. Otherwise, Exchange plans will not be on a level playing field relative to plans offered outside the Exchange.

Subpart C – General Functions of an Exchange
§155.200 Functions of an Exchange

AARP supports the idea that the Exchange should be an active partner in efforts to improve the value and the quality of care provided by the plans in the Exchange. AARP understands that appropriate plan management strategies may vary from area to area and over time within an area depending on market conditions. We urge HHS to condition approval of State Exchanges and Partnership Exchanges on the entity responsible for plan management. Providing an entity with the authority to undertake the range of business strategies that it may need to develop the Exchange marketplace and work to improve value and quality of its QHPs is a substantial task. We also applaud HHS's efforts to support the importance of streamlined, coordinated eligibility and enrollment so that the experience of consumers seeking coverage and subsidies through the Exchange is as simple as possible. Future HHS regulations that provide more detail on the rating of health plans, consumer satisfaction surveys, and data reporting related to quality and outcomes should reinforce the importance of these functions. Evaluation and measurement are important Exchange responsibilities. Exchanges should examine past performance when they initially certify plans for participation in the Exchange as well as conduct ongoing review to ensure appropriate levels of quality.

§155.205 Required consumer assistance tools and programs of an Exchange

Making the consumer assistance tools friendly and effective for the variety of users is critical. Health insurance is a complex product that even sophisticated users can find hard to understand. For that reason, providing information in a clear and consistent format that guides consumers through relevant choices and considerations related to their choices is integral to the success of an Exchange. We are pleased that HHS envisions the Exchange web site as an easy-to-use access point that serves as a primary source of information about available QHPs, Exchange activities, and other sources of health coverage, as well as other information. HHS may want to provide templates that can serve as examples.

It is important for consumers to have ready access to all the information they need to make informed decisions about their coverage and to identify any programs that may provide assistance for which they qualify. At §155.205(b)(1), HHS specifically proposes that the Exchange web site presents: standardized comparative information on each available QHP; premium and cost-sharing information; summary of benefits and coverage information; level of coverage offered; results of enrollee satisfaction surveys; quality ratings; medical/loss ratios; transparency of coverage measures; and a provider directory. In addition, at §155.205(c), HHS proposes to codify the statutory requirement for an electronic calculator to assist individuals in comparing the costs of coverage in available QHPs after the application of any advance payments of the premium tax credit and cost-sharing reductions. AARP strongly supports codification of this requirement in the regulations and urges HHS to require Exchanges to provide consumers with a way to calculate their expected premiums and out-of-pocket costs. Consumers must have information that helps them know what their health care costs are likely to be in any given plan. We know from our members and others that overall cost comparisons are a top priority that they want to factor into their decisions. Given the existence of calculators that could provide the necessary information, such as the tool developed by the nonprofit Consumers' CHECKBOOK that is currently made available in the *Guide to Health Plans for Federal Employees and Annuitants*, we know that it is already feasible to provide useful information on out-of-pocket costs that are based on actuarial estimates for persons of similar age and family size using data from the Medical Expenditure Panel Survey produced by the Agency for Healthcare Quality and Research (and other sources). The Consumers' CHECKBOOK tool allows the user to drill down to obtain information on the risk of very high costs under each plan, coverage and cost-sharing provisions, and special coverage features, but it is also possible to get a quick estimate for those who are not interested in details.

AARP agrees with the desirability of avoiding duplication of effort, but believes that the role of the Exchange call center is inherently different from that of a QHP's customer call center. The Exchange call center must have the capacity to provide objective information on the array of public coverage options (Medicaid, CHIP, etc.), comparative data on QHPs available to individuals and small businesses and their employees, and details on subsidies. For the call center to be effective, it is especially important for operators to know the specific rules governing enrollee appeals rights and to have knowledge of community resources. In addition, the call center should have the capacity to provide follow-up information to reinforce the information conveyed during the call, either through electronic means or by mail. On the other hand, the navigator program is more focused on providing support to individuals needing assistance. AARP urges CMS to use lessons learned from Medicare's call center related to the Medicare Advantage and Medicare Drug program to inform Exchanges on how to avoid duplication of effort by the Exchange and QHP call centers. Sharing those lessons with Exchanges would be beneficial. We are aware that Medicare has made adjustments to the call-center over time as it has gained experience and learned more about what type of assistance beneficiaries need.

AARP believes there is need for information on HealthCare.gov in addition to state-specific Exchange websites. HealthCare.gov provides a single location for information about health plans across the country and the premium tax credit. The current site allows consumers to find out about the Pre-existing Condition Insurance Program (PCIP) in their state as well as existing public and private coverage options. It is similar in function to Medicare.gov in that it is an entry point for information on Medicare, Medicare Advantage, Medicare Rx plans, and nursing home compare. A single source of information provides consumers with an entry point that allows them to pursue additional information. Exchange websites provide a central place to find information about QHPs offered for that specific Exchange. AARP believes exchange websites should also include information on the premium tax credit. We believe it is vital for all Exchange websites to link to HealthCare.gov to provide additional information on an individual's coverage options.

AARP recently commissioned research that looked at existing consumer information websites and provided recommendations on attributes of public reporting that enhance the consumer experience in obtaining information. The report[1] is based on a review of existing websites and provides recommendations on a range of topics that may be helpful to HHS in developing templates for providing comparative plan information to consumers. The recommendations address information presentation and navigation, education and decision support, limiting the number of health plan choices, health plan performance -- including complaints/grievances and appeals -- as well as other types of performance information (quality, cost), and integrating information about individual providers with information about the plans.

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[1]Cronin, Carol. "State Health Insurance Exchange Websites" A review, discussion and recommendations for providing Consumers Information about Quality and Performance," AARP, July 2011. http://www.aarp.org/content/dam/aarp/health/medicare_insurance/2011-07/2011-cronin-report-final.pdf

The preamble seeks comment on the idea of encouraging Exchanges to develop a feature whereby eligibility and enrollment experts, caseworkers, Navigators, agents and brokers, and other application assisters are able to maintain a record of individuals they have assisted. In order to evaluate whether to encourage this feature, AARP would need to understand the goal of this feature and its advantage for consumers. AARP believes strongly that *if* this function is included, the rule must add provisions that protect the privacy of any personal and health information that is collected and retained in the record and narrowly limit uses of the information to those that simplify the application and enrollment process for the consumer. The information should be subject to the same HIPAA privacy and other protections we propose for other personal and financial information. Further, regulations should specify that such information is not to be used for marketing purposes.

§155.210 Navigator program standards

AARP supports the proposal to require multiple categories of Navigators in each state. AARP believes the regulations should require that at least one Navigator entity be a community and consumer-focused non-profit organization. For consumers with existing relationships with community-based organizations, a high level of trust in the relationship may already exist. Among members of communities that may be less familiar with health insurance, trust in relationships with existing community-based organizations may be central to effective outreach. Given the Exchanges' target audiences, we believe that a range of types of entities will be needed to effectively reach the various audiences including those with experience with underserved, difficult to reach and low-income populations, the uninsured, and those for whom cultural and language barriers exist.

Significant portions of the uninsured in all states will be eligible for Medicaid in 2014. And, many consumers will experience changes in income or other circumstances which will warrant transitions between Exchange and Medicaid coverage. Navigators should be able to assist. AARP suggests that, in addition to the requirements set forth in the proposed regulations, Navigators be required to advise and assist consumers eligible for Medicaid, CHIP and other state health programs which may be accessed through the Exchange. In addition, we believe this requirement would be consistent with the ACA's emphasis on easy, simple access to coverage for consumers and small businesses and a one-stop marketplace with a single seamless application system.

To prevent conflicts of interest, the prohibition on Navigator compensation from insurers should extend to insurance products sold outside the Exchange. Without such a prohibition, there could be financial incentives for Navigators to steer individuals to non-Exchange products and their responsibility to provide fair, accurate and impartial information about Exchange and non-Exchange products would be compromised. Moreover, the public perception of Navigators' integrity will be damaged if some Navigators are able to profit from non-Exchange sales. We are particularly concerned about unintended consequences if those not eligible for tax subsidies are steered to non-Exchange products; this might result in adverse selection to the detriment of the Exchange and QHPs.

To ensure that information provided by Navigators is fair, accurate, and impartial, a standard could be added that requires all written and other information and education materials to be submitted for review and approval by the Exchange before they are used by Navigators. Another approach would be for the Exchange to provide materials for use by Navigators. HHS may want to draw on its experience with the Medicare program, where it reviews materials for the Medicare Advantage programs, provides standardized templates that plans can draw on, and works with State Health Insurance Counseling programs.

We strongly urge that the Exchanges be required to ensure that the Navigator program is fully operational no later than the first day of the initial open enrollment period. The need for Navigator assistance will never be greater than during the initial enrollment period. Timely start up will require that Exchanges establish grant and certification standards and award grants well in advance of the start of the initial open enrollment period. If an Exchange cannot demonstrate that it will have trained Navigators in place, HHS should not grant the Exchange final approval or approve a partnership agreement for this core function – rather, HHS will need to step in to oversee and conduct the Navigation program.

§155.220 Agents and Brokers

AARP believes consumers will be best served by having a variety of options available to them for enrolling in QHPs. This may be direct online enrollment or purchasing coverage *with or without* the use of agents or brokers. While AARP agrees that states should have the option to allow producers to enroll people in QHPs, we believe the regulations should explicitly prohibit any state from compelling enrollment by agents and broker for all QHP sales. AARP has opposed state legislation that would have allowed QHP enrollment only through a broker or agent.

For states that choose to allow producer enrollments, additional regulatory safeguards should be included. Without a level playing field between insurance sold inside and outside the Exchange, successful implementation of the ACA will be jeopardized. Any compensation system for agents/brokers should prohibit steering of consumers and should be free of any incentives for or against QHPs sales. This could be accomplished by allowing agents and brokers to sell QHPs only if there is a uniform compensation system for sales they make on products inside or outside the Exchange.

The ACA requires Exchanges to keep insurance costs affordable, prevent waste, and publicly disclose its administrative costs and other payments required by the Exchange. HHS should require disclosure of all compensation paid to agents and brokers to those purchasing through them. And, as part of the rate review process, HHS should track the impact of these costs on premiums overall.

AARP urges HHS to modify the proposed rule on web site disclosure. The rule allows a state to elect to provide information regarding licensed agents and brokers on its web site for the convenience of consumers. If an Exchange does this, the rule should also provide a similar level of information about Navigators and other consumer assistance resources.

§155.240 Payment of Premiums

For consumers, there are two interests with respect to payment of premiums. The process should be easy, and protections must apply to all those involved in the premium payment process.

§155.260 and 155.270 Privacy and Security of Information/Use of Standards and Protocols for Electronic Transactions.

The Exchanges will be handling personally identifiable information received from individuals applying for insurance coverage and subsidies. In addition, they regularly will receive such information from QHPs. Therefore, we strongly agree with the proposal to require that the Exchanges be held accountable for having appropriate security and privacy safeguards and to require that entities with which the Exchanges contract (or subcontract) be similarly required to meet rigorous standards to protect the privacy of individuals and the confidentiality of the data they handle. These requirements are critically important to assure the public that personal health information will be treated properly.

In the preamble, CMS acknowledges that it is difficult to apply a consistent set of privacy standards to the Exchanges because they will not all be organized in a consistent manner. For example, at least some of the Exchanges may be HIPAA-covered entities or business associates of HIPAA-covered entities, in which case, they must comply with HIPAA requirements. AARP supports the application of the Fair Information Practice Principles (FIPPs) as the foundation for privacy protections in the Exchanges; the HIPAA security rules; to the extent applicable, the HIPAA privacy rule (e.g., those that address "individual rights" – right to: notices of privacy practices; amend personal information; access to copies of personal information; and receipt of an accounting of how personal information has been disclosed); and the additional privacy protections proposed (e.g., concerning written policies, extending requirements to contractors that are the same or higher than those applicable to the Exchanges). In combination, these will establish the necessary framework to ensure that the confidentiality of personal health information is maintained and data are treated in secure environments.

As an overarching principle, Exchanges' use of and access to personally identifiable information should be limited to only the information they need to carry out their responsibilities. This view is supported by the provision of the ACA that restricts the Exchanges' use of personally identifiable information to only that which is needed for the efficient operation of the Exchange (section 1411(g)(2)). We are concerned that the proposed rule at §155.26(b) allows greater leeway than a strict interpretation of the statute would allow by permitting "other applicable law" (that may not necessarily pertain to the operation of Exchanges) to govern use of personally identifiable information. We prefer that the rules adhere to the statutory intent and urge the final rule to reflect the strict limitations imposed on the Exchanges, as envisioned in the statute. In addition, we strongly urge that the collection, use, and disclosure of Social Security numbers be strictly limited to determining the eligibility status of an individual applying for coverage or subsidies.

Privacy and data security policies should be part of the Exchanges' written Exchange plan (as well as the corresponding document for federally-organized Exchanges.) The Exchanges should be required to have privacy and security policies that are transparent and fully disclosed and disseminated to the public. The development of privacy policies should be an open process that allows all stakeholders, including consumers, to participate and offer input. As we note elsewhere, public input into the development of privacy policies (and other processes) should be an ongoing practice of the Exchanges.

Finally, AARP strongly encourages active oversight of the privacy and data security provisions of the statute and regulations. The proposed rule codifies the statutory provision for civil penalties of up to $25,000 per disclosure for improper use and disclosure of information (in addition to other applicable penalties). HIPAA allows for harsher (criminal) penalties for knowing and willful violations of the requirements and lesser penalties for less egregious violations (e.g., negligence). We think such a penalty structure should apply to the Exchanges as well, although we understand this may require a statutory change.

Subpart E – Exchange Function in the Individual Market: Enrollment in Qualified Health Plans
§155.400 Enrollment of Individuals in QHPs

AARP believes that enrollment transactions should be straightforward, easy to accomplish, and processed and acknowledged as quickly as possible, preferably in real time. As states progress toward real time processing, QHPs should be required to complete and acknowledge enrollment election requests promptly. If an individual's enrollment is facilitated by a Navigator, for instance, Navigators may then have to convey the information to the Exchange. In this and similar situations, enrollees should receive confirmation that their enrollment has been received by the relevant QHP. In Medicare Part D, timeliness of the enrollment process is addressed in the regulation; a similar approach should occur here. AARP believes strongly that consumers must have protection that their enrollments will be processed quickly so that problems such as missing information or inaccuracies in processing can be addressed and corrected quickly. Consumers should not face delays in the effective date of their enrollment because of untimely processing.

§155.405 Single Streamlined Application

The ease of the application form and process is very important for consumers; complexity discourages people from completing the process. Currently, the complexity of applying for public programs or shopping for health coverage in the private individual market often causes potential beneficiaries to abandon the process and go without coverage. A goal in establishing Exchanges is to simplify the experience of those accessing individual market plans, public coverage options, and new premiums tax credits and cost-sharing subsidies. AARP thinks it is important to keep the application simple; that means questions that are not pertinent to the eligibility and enrollment process should not be asked on the application. We think this should be codified and applied to all alternative applications HHS may be asked to approve.

AARP also urges that people be given the option to file an application in-person. The target population includes people who may not be familiar with health insurance, those who have poor health literacy or decision-making skills, and language or other limitations. They may need assistance filling out the application or have questions about how to complete it correctly. The simplest way for them to do this may be in-person rather than by phone or on the Internet. The rules should include an in-person option for filing an application.

The streamlined application should describe the privacy and security protections that are required of the QHP and the Exchange with respect to the handling of personal health information, including access, consent and control, audit, correction, etc.

§155.410 Initial and Annual Open Enrollment Periods

In view of the large scale effort that will be needed to inform and educate the public about the Exchange in their state and the opportunities for subsidies, AARP strongly supports a five month initial open enrollment period. An initial enrollment period of this nature allows for public outreach and education, as well as ample time for consumers to apply and enroll in QHPs offered on the Exchange.

The proposed rule calls for coverage to begin on the first day of the month in the initial open enrollment period, as well as special enrollment periods. This follows from the statutory provision that premium tax credits are only provided for someone who is enrolled on the first of the month. We believe that CMS should permit Exchanges the flexibility of allowing additional effective dates so long as they comply with the first of the month requirement specified in the statute. Of course, in these states where this option is exercised, it will be necessary to ensure that the public is fully apprised of the additional dates.

AARP believes it is important to provide enrollees with a notice of an upcoming annual open enrollment period to remind them that they will have an opportunity to review their current QHP selection. Medicare beneficiaries receive such notice, and those enrolling through Exchanges should have similar advance notice and information about sources of information about available QHPs. We urge HHS to design templates to provide to the Exchanges to ensure that all necessary information is included in these notices.

In situations where an individual's current QHP will not be offered in the Exchange for a subsequent year, AARP expects that the individual would have received a notice of termination from their current QHP (under § 156.270) informing them that the particular QHP will no longer be available, and that they must select another one. Any auto enrollment would be a fallback for those who fail to take action. AARP conditionally supports auto enrollment as a measure to prevent subsidized individuals from becoming uninsured or facing a gap in coverage. We believe that auto enrollment must also involve notice to the individual and an opportunity to elect a different plan within a certain time frame, e.g., 60 days. Any auto enrollment should aim to put an individual in a plan that is the same or as close as possible in terms of benefit design, cost, and provider network as the one in which they were previously enrolled. If an individual who has been auto enrolled in a QHP does not elect to opt out, the enrollment should last through the enrollment year.

§155.420 Special Enrollment

AARP supports giving people a special enrollment period when their eligibility for premium tax credits or cost-sharing reductions changes, as this will affect their out-of-pocket costs for coverage. We think that the 60-day period in which they can change plans should start at the time that the individual is made aware of the change in their eligibility status. We also support timing the special enrollment period for those losing minimum essential coverage from an employer to overlap with the employer's open enrollment period, since that is when the employee would learn about changes for the upcoming employer health plan year. But since employer open enrollment periods generally occur a couple of months before the new plan year (e.g., plan choices for the following year are made in October for January 1, or in May for July 1), the rule should allow for the effective date of QHP coverage during such a special enrollment period to pick up when their current employer plan year ends. This would ensure that the individual doesn't become uninsured, and that they don't have to drop employer coverage early if they don't want to, or have duplicate coverage for some period of time.

For special enrollments triggered by a permanent move, AARP supports the option of starting the 60 day period on the later of either the date of the permanent move or when the individual provides notice of the move to the current exchange or new exchange within a reasonable time frame, provided there is interoperability between the exchanges. At the time of a permanent move, an individual is attending to many details and may not immediately find time to research the coverage options in their new area and make the decision that a new plan is a better fit for their needs.

AARP understands the goal of limiting adverse selection among QHP plans by generally limiting plan changes during special enrollment periods to those in the same level of coverage. AARP supports the proposed exception to this rule when the special enrollment is triggered by change in eligibility for subsidies. The gain or loss of eligibility for premium and/or cost sharing subsidies has a clear impact on an individual's out-of-pocket cost for coverage. Gaining eligibility for subsidies may make coverage in a higher level QHP affordable when it may not have been without that assistance. Similarly, loss of eligibility may make one's current level of coverage unaffordable, and may necessitate switching to a less costly QHP.

Subpart H – Exchange Functions: Small Business Health Options Program (SHOP)
§155.705 Function of a SHOP

The goal of the SHOP is to try to improve the health insurance marketplace for small employers and their employees by providing them with new options and potentially leveraging their buying power to greater effect than in the current small group marketplace. The SHOP would allow small employers to continue to pick a single QHP offered through the SHOP for their employees, or offer more choices. As HHS is interpreting the statute, it would permit SHOP exchanges to allow employers to select:

- one or more specific QHPs to make available to their employees,
- a single plan level from which employees could choose a plan, or
- allowing employees to choose a plan from any plan level.

This interpretation maximizes employer and potentially employee choice. If an employer chooses to offer employees a choice of multiple plans in the same or multiple levels of coverage, this may erode the common practice of composite group rates. Employee premiums will be based on their individual characteristics, (e.g. age, family size, smoking status), and older employees will find themselves shouldering a larger portion of the premium than they would if their employer pre-selected a single plan or plans and received a composite group premium. As a result, increased choice adds complexity for employees that the proposed rule does not address.

AARP is concerned that the rule does not adequately address the employees' information needs in situations where employees may choose among multiple plans, and urges HHS to address this need. Since the SHOP does not involve premium and cost-sharing subsidies, the proposed rule exempts the SHOP from providing a calculator function to assist employees in making plan selections. If employees can pick from multiple plans and possibly multiple plan levels, they will need information to assist them when making their plan selections. AARP believes strongly that HHS rules should require that SHOP assures employees have information that enables them to know their premium contribution after their employer contribution when choosing among different SHOP plans. This is particularly important as the choice offered in the SHOPS means different employees will be charged different premiums based on age and/or family size. Knowing one's premium contribution is critical information for consumers trying to make the best choice for themselves and their families. SHOPs should provide a means for employees to calculate their premium cost.

§155.715 Eligibility Determination Process for SHOP

AARP believes that HHS should require that when an employer withdraws from SHOP the notice to employees should inform the employee about his or her eligibility for special enrollment periods in the Exchange and the process of determining whether they may be eligible for premium and cost sharing subsidies or public coverage options.

Subpart K – Exchange Functions: Certification of Qualified Health Plans
§155.1000 Certification Standards for QHPs

AARP understands that there are multiple factors that can enter into a determination of whether offering a health plan is in the public interest, and that the markets differ across the country. AARP believes that the federal government can legitimately set high standards for access to the marketplace in which federal dollars will subsidize private health coverage. While in some markets there may be limited competition and a need to accept all qualified health plans, in others the target population may be sizeable and there may be strong competition. AARP believes Exchanges should work to improve the affordability and quality of plan offerings by using market tools in much the same way that large employers try to help improve value and quality for the dollars being spent.

§155.1020 QHP Issuer Rate and Benefit Information

AARP is pleased that the proposed rule is clear that the Exchange is to consider a plan's rate increases in certifying QHPs. If the Exchange is to drive improvements in plan value and quality, it needs to review the information on QHP premium trends and increases to understand what is driving cost increases, regardless of the magnitude of the increases.

AARP supports the goal of minimizing duplication of effort where a state regulatory authority has the resources and is providing adequate review of unreasonable premium increases. AARP believes that if HHS proceeds with a bifurcated process, it should make that contingent upon a state's effective review of unreasonable rates and their being a formal collaborative arrangement between the state regulatory authority and the Exchange. Under any such bifurcated arrangement, the Exchange should have responsibility for reviewing proposed rate increases and their justifications for all plans not reviewed under the collaborative arrangement. QHPs rate increases must not be given a pass simply because they do not hit the threshold for being potentially unreasonable, and information on rate increases should be transparent to the public.

§155.1050 Establishment of Exchange Network Adequacy Standards

AARP supports a requirement that QHPs must be able to demonstrate that appropriate and necessary services are reasonably available and accessible 24 hours a day and seven days a week. Plans must have sufficient numbers of practitioners, providers, and facilities and sufficient distribution of providers by specialty and location within a plan's service area to serve enrolled members. Future requirements will further define expectations with respect to quality, safety and efficiency. Here, we simply emphasize that having an adequate network does not mean that "larger is necessarily better." We fully expect QHPs to pay attention to the performance of the providers and practitioners with which they contract in order to assure enrollees receive value for their health dollars.

The adequacy of a network should be assessed in relation to the type of health plan, the prevailing patterns of provider distribution in the plan's geographic service area, and the needs of the plan's enrollees. We agree that Exchanges should establish specific standards that would require QHP issuers to maintain: 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 enrollee; 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. HHS would allow Exchanges to set quantitative requirements where possible.

AARP strongly supports an additional standard for the Exchange to ensure that the QHP's provider networks provide sufficient access to care for all enrollees, including those in medically underserved areas and regardless of the enrollee's medical condition. Unless a QHP's network offers adequate access to all services, enrollees will not be able to get the care and benefits for which they are paying their premiums.

QHP's should assure that network providers are qualified, credentialed and in good standing. Networks also should be constructed to ensure that there is adequate capacity to address the language and cultural preferences of enrollees. Network adequacy standards should ensure appropriate access to services--quick access to care when needed and reasonable access for routine care.

Exchanges and plans should monitor the adequacy of QHP networks through beneficiary complaint records and other oversight approaches, including accreditation requirements, and performance assessment

§155.1075 Recertification of QHPs

AARP supports the proposed timeline for recertification of QHPs. Plans should be recertified annually in advance of the annual open enrollment period.

§155.1080 Decertification of QHPs

Exchanges should have a process in place for decertifying QHPs that the Exchange determines are no longer conforming to certification criteria, for example, related to network adequacy and quality. Depending upon the nature of the issue, there could be sanctions that the Exchange could use prior to decertification.

If a plan is decertified it is critical that the process provide for an orderly transition for enrollees. The rule provides for notifying them about their special enrollment right, but AARP would suggest that the process be expanded. There should be a provision for default auto enrollment into another QHP if an enrollee fails to exercise their special enrollment rights (with the proviso about disclosing auto enrollment and their right to change).

Should there be a repeat decertification, a plan should not be re-certified for a period of time.

Part 156-Health Insurance Issuer Standards Under the ACA, Including Standards Related to Exchanges
§156.220 Transparency in Coverage

AARP supports the requirement for transparency on QHP claims policies, financial disclosures, enrollment data, disenrollment, and claims denials, rating practices and information on enrollee cost-sharing. The information should be published in a place where the public can get access to it, and in a format that the public can understand. If the consumer wants to compare policies and practices of various plans, it would be helpful if the Exchange provided a template for QHPs to use in presenting the information, so that the information will be consistent across plans.

AARP applauds the requirement for transparency of enrollee cost-sharing. A plain language standard should also apply to this information, and it should be available in hard copy or by phone for those without access to the web. Enrollees should be able to know what amount they will be expected to pay for care from a particular provider under the terms of their plan. Such information helps them to assess quality and value.

§156.225 Marketing of QHPs

AARP supports the approach of making compliance with state laws on insurance marketing a condition of certification for QHPs. A broad prohibition against unfair marketing and deceptive marketing practices by all QHP issuers and their officials, agents, and representatives would serve to reinforce state laws in this area, and provide authority to the Exchange to pursue problems if they are falling through the cracks. Experience in the Medicare program shows the importance of close cooperation and timely sharing of information among state and federal regulators responsible for overseeing that plans and brokers market products in a fair and honest way.

AARP would suggest that the Exchange should also review and approve QHP marketing materials for Exchange plans and may also want to review their QHP marketing plan.

AARP shares the concern about potential misrepresentation of the advantages of enrolling in QHPs to vulnerable individuals and those who are not familiar with insurance and the marketing practices of issuers and agents. We are also concerned about the potential for inappropriately steering people to plans outside the Exchange. Plans should not be sold to people on Medicare. People with other private or public coverage should not be inappropriately urged to drop it and replace it with QHP coverage if it is not in their best interest. To the extent that people are applying for subsidies or enrolling through the Exchange, the presence of other coverage should be discovered then. If someone is inappropriately being sold QHP coverage this needs to be addressed. Standards for addressing this problem need to be identified by the agency and included in future rulemaking -- it is critical those standards be designed to protect consumers.

§156.235 Essential Community Providers

AARP recognizes the challenge of access to primary care, and supports expansion of the definition of “essential community provider” to include nurse-managed health clinics (NMHCs). Nurse-managed health clinics provide a full range of health services and can serve as designated primary care providers. They are a valuable source of primary care for vulnerable and medically underserved populations in some metropolitan and rural areas providing services comparable to those of federally-qualified health centers. We also think it is important to permit flexibility that recognizes new forms of service delivery, including the use of health information technology that permits non-face-to-face encounters.

§156.265 Enrollment Process for Qualified Individuals

The standard for the frequency of electronic transmittal of enrollment information should be as often as necessary to assure enrollees’ that their coverage will start on a timely basis.

With respect to the content of the enrollment packet, the QHP enrollee should receive everything that they need to navigate and access care under their coverage. Beyond the enrollment/ID card, information on how to access care, the summary of benefit and coverage document, information on how to access the provider director and drug formulary, and how to submit a request for hard copy of the information. The materials should also include information on how to access the enrollee cost-sharing transparency information and information informing non-English speakers how they can access plan information.

§156.270 Termination of Coverage for Qualified Individuals

Termination notices should provide clear information to individuals, informing them:

- the reason for the termination;
- action they can take to prevent termination and the date(s) by which they must do so;
- where they should call with questions or if they think a mistake has been made; and
- the date coverage will end if they don't address the reason for the termination

If non-payment of premiums is the reason, the notice should provide information about the grace period for those receiving advance payment tax credits. If there are any appeal rights, these should be noted. The notice might also include information about consumer assistance or ombudsman programs.

For non-English speakers there should be an indication of where they can call for assistance.

§156.295 Prescription Drug Distribution and Cost Reporting

The proposed rule calls for reporting on the aggregate amount of the rebates, discounts, or price concession that are passed through to the QHP issuer. AARP suggests that HHS also consider reporting on the aggregate amount of discounts/rebates/price concessions that are passed through to plan enrollees.

Finally, as the Exchanges are developed, CMS should keep in mind how the Exchanges might be used to reduce health and health care disparities, as well as how to meet some of the unique needs of minority and other vulnerable populations. The application of Title VI of the Civil Rights Act of 1964 as well as § 1557 of the ACA to this proposed rule is vital not only to prohibiting discrimination on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation but also to ensuring the provision of competent and comprehensive language services to people with Limited English Proficiency

AARP appreciates this opportunity to comment and will be pleased to work with CCIIO and through our states offices with the States and Exchanges in implementing this key feature of reform. If you have any questions, please feel free to contact Leah Cohen Hirsch of our Government Affairs staff at 202-434-3770.

Sincerely,

David Certner

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