ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

July 19, 2013

Secretary Kathleen Sebelius
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 20144-1850

Re: **CMS-9957-P – Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards**

Submitted via website at http://www.regulations.gov

Dear Secretary Sebelius:

Consumers Union, the policy and advocacy division of Consumer Reports, submits these comments regarding the proposed rule, CMS-9957-P, addressing a wide variety of consumer issues. Note that these comments are organized in the order they appear in the federal register and specific recommendations for language changes have been underlined or struck through and included in red text.

**Clarifying Rating Area for Small Group Market – §147.102(a)(1)(ii)**

This section clarifies that the rating area is determined in the small group market using the principal business address of the group policyholder, and in the individual market, using the address of the primary policyholder, regardless of the location of other individuals covered under the plan or coverage.

Consumers Union supports these provisions because they simplify the determination of premium rates and make this determination more transparent.

**Risk Adjustment – §153.310 risk adjustment administration and §153.620 compliance with risk adjustment standards**

A key element to success of the risk adjustment program will be the ability to validate the data in order to secure accurate risk adjustment payment and ensure issuer confidence in the program. To that end, Consumers Union supports the proposed requirement that states maintain documents and records related to the risk adjustment programs they operate for at least 10 years and make them available upon request from HHS, OIG, the Comptroller General, or other designees. This time period is consistent

Consumers Union
Headquarters Office
101 Truman Avenue
Yonkers, New York 10703-1057
(914) 378-2029
(914) 378-2992 (fax)

Washington Office
1101 17th Street, NW #500
Washington, DC 20036
(202) 462-6262
(202) 265-9548 (fax)

West Coast Office
1535 Mission Street
San Francisco, CA 94103-2512
(415) 461-6747
(415) 431-0906 (fax)

South West Office
506 West 14th Street, Suite A
Austin, TX 78701
(512) 477-4431
(512) 477-8934 (fax)

with other retention requirements in the proposed rule and under the ACA, Medicare, and Medicaid. Consumers Union agrees that the requirement should also apply to a state's contractors, subcontractors, and agents. It should also explicitly apply to any data validation auditors used by the state and by issuers themselves for initial validation.

We also support the requirement that the state submit an interim report and a detailed summary of its risk adjustment operations to HHS. The detailed summary should include state analysis of trends to allow HHS to learn from and better work with states to calibrate HHS' risk adjustment model. It would also allow HHS and states to identify upcoding trends, problem areas and issuers, as well as improve the overall data validation process.

In addition, we recommend that HHS reserve the authority to use this information to cross-check whether issuers are out of compliance with certain other requirements under the ACA. For example, such information could be used to help determine whether issuers are in compliance with the single risk-pool requirement across all of their plans offered inside and outside the Exchange under section 1312(c) of the Affordable Care Act.

> **CU recommendation**: Amend the language in §153.310(c)(4) to read: "(4) Maintenance of records. A State operating a risk adjustment program must maintain documents and records relating to the risk adjustment program, whether paper, electronic, or in other media, for each benefit year for at least 10 years, and make them available upon request from HHS, the OIG, the Comptroller General, or their designees, and state validation auditors, to any such entity. The documents and records must be sufficient to enable the evaluation of the State-operated risk adjustment program's compliance with Federal standards. A State operating a risk adjustment program must also ensure that its contractors, subcontractors, and agents similarly maintain and make relevant documents and records available upon request from HHS, the OIG, the Comptroller General, or their designees, and state validation auditors, to any such entity."
>
> **CU recommendation**: Amend the language in §153.620(b) to read: Issuer records maintenance requirements. An issuer that offers risk adjustment covered plans must also maintain documents and records, whether paper, electronic, or in other media, sufficient to enable the evaluation of the issuer's compliance with applicable risk adjustment standards, including initial data validation, and must make that evidence available upon request to HHS, OIG, the Comptroller General, or their designees, or in a State where the State is operating risk adjustment, the State or its designee, and the issuer's data validation auditor, to any such entity.

**Failure to comply with HHS-operated risk adjustment and reinsurance data requirements – §153.740**

Consumers Union strongly supports the proposal to impose a mandatory default risk adjustment charge, and at HHS' option to impose a civil monetary penalty if an issuer fails to establish a dedicated, distributed data environment, fails to provide HHS with access to the required data, or otherwise fails to comply with federal risk adjustment requirements.

Default risk adjustment charges and optional civil penalties are necessary due to the grave, systemic implications of an issuer not complying with the data requirements in a timely manner. For example, since HHS is not itself collecting the data, but rather relying on issuers establishing distributed systems, if an issuer does not set up a dedicated distributed data system on a timely basis or submits inaccurate or incomplete data, HHS would not be able to perform accurate risk adjustment calculations for the state (in states where HHS is operating the risk adjustment system) because payment transfers are determined for an entire market within a state and must net to zero. Omitting the non-compliant issuer from the calculation is not a valid solution since doing so would adversely affect all other issuers in the state, resulting in some issuers making smaller payments than warranted and payments by other issuers larger than they should be. This would undermine the accuracy, fairness, and ultimately trust in the risk adjustment system. Assessing a default risk adjustment charge in a sufficient amount would incentivize compliance and avoid delaying or distorting risk adjustment calculations and preserve the integrity of the risk adjustment process.

Consumers Union supports HHS' authority to assess civil monetary penalties on issuers, in addition to the default risk adjustment charge, for repeated non-compliance. For example, issuers should be subject to civil monetary penalties if issuers are out of compliance in two or more benefit years or fail to correct significant deficiencies discovered during the initial and secondary validation audit process that result in substantially inaccurate data or produce significant upcoding trends.

**Establishment of a State Exchange, Approval of a State Exchange – §§155.105 and 155.140**

Consumers Union opposes permitting a state that elects to operate its own SHOP, but not an individual market Exchange, to establish a risk adjustment program that applies solely to its small group market. This could result in two different risk adjustment models operating in the individual and small group markets in the state. Certainly some issuers participating in one state Exchange market will also participate in the other, having different risk adjustment models could lead to undue burden and complexity for issuers in terms of data collection and reporting and calculation of premiums. It also could result in less accurate risk adjustment calculations and greater incidence of non-compliance with federal and state risk adjustment requirements. That would undercut the ability of risk adjustment to stabilize premiums overall in the state's individual and small group markets, due to differing effects on premiums and issuer behavior.

**CU recommendation**: HHS should not allow a state that elects to operate its own SHOP, but not an individual market Exchange, to establish a risk adjustment program that applies solely to its small group market.

**Web-Brokers – §155.220(c)(3)**

This section establishes standards that apply if an agent or broker uses its publicly-facing internet website to assist individuals in selecting or enrolling in a QHP through the Exchange, referred to as "Web-brokers." The NPRM proposes to revise the web-brokers' obligation to display *all* QHP information to a reduced obligation to display just the QHP information *provided by the Exchange or directly by the issuer.*

The revision means that web-based brokers are likely to end up displaying less-than-complete information about QHPs offered by the Exchange,[1] reflecting instances when information is not supplied by either the Exchange or the issuer.

We are very concerned about this proposed change. It seems likely that web-based broker displays will list complete information for some plans (such as those with whom the web-broker has contracted to receive a commission) and incomplete information for other products, creating a very different and inherently biased shopping experience for consumers.[2]

Such a display might look like this:

| **Health Plan Name** | **Metal Level** | **Premium Quote** | **Deductible** | **Office Visit Co-pay** | **Quality Rating** | **Summary of Benefits and Coverage** |
|---|---|---|---|---|---|---|
| Plan C | Bronze | $700 | $3,000 | $40 | ★★★ | Link |
| Plan D | Bronze | $700 | $2,900 | $45 | ★★★ | Link |
| Plan E | Bronze | $700 | $3,100 | $60 | ★★★ | Link |
| Plan A | Bronze | **N/A** see healthcare.gov | **N/A** see healthcare.gov | **N/A** see healthcare.gov | **N/A** see healthcare.gov | Link |
| Plan B | Bronze | **N/A** see healthcare.gov | **N/A** see healthcare.gov | **N/A** see healthcare.gov | **N/A** see healthcare.gov | Link |

[1] The prior rule required the display of these QHP attributes for all plans: a) premium and cost-sharing information; (b) summary of benefits and coverage; (c) metal level (bronze, silver, gold, or platinum); (d) enrollee satisfaction survey results; (e) quality ratings; (f) medical loss ratio, (g) transparency of coverage measures, and (h) provider directory.

2 See Consumers Union, *Recommended Consumer Protections for Web-based Agents and Brokers offering Exchange Coverage*, September 2012.

Research shows that consumers are likely to select from among the options that feature complete information, without clicking through to see their other, possibly more optimal, plan options.[3]

Our understanding of the reason for this change is that information on the factors making up premium rates could be considered proprietary and thus the Exchange may not have permission to share them with web-based brokers. Further, our understanding is that while final premium rates are not considered proprietary, they are too numerous to convey to web-based brokers for use on their site.

We do not find this rationale creditable. The factors making up a rate are easily determined by comparative analysis and therefore cannot be considered proprietary. For example, comparing the same plan for the same type of person in two different rating areas will reveal the portion of the rate attributable to the geographic rating factor. Similarly, comparing two plans for the same person in the same geographic rating area will reveal the difference attributable to differences in plan design.

Web-based broker displays that do not treat all QHPs equally have no place in the post-ACA world. Such displays are not consistent with the improved, unbiased shopping experience that the ACA is supposed to be delivering for consumers. Implausible claims about proprietary rating factors should not provide the basis for this proposed change. Indeed, a condition of QHP participation in the Exchange could be that such information must be shared with web-based entities, after they have ensured its confidentiality as part of their agreement with the Exchange.

> **CU Recommendation:** We recommend against the proposed change to §155.220(c)(3)(i) and support preserving the language as previously articulated in the final March 2012 regulations: "~~Disclose~~ Meet all standards for disclosure and display ~~all~~ of QHP information ~~provided by the Exchange or directly by QHP issues consistent with the requirements of~~ contained in §155.205(b)(1) and §155.205 (c).~~), and display a Web link to the Exchange Web site~~."

An alternative approach that would address consumers' needs, though less preferable, is to require web-brokers to use an I-frame to display the QHP options available to the consumer. Indeed, this is an approach that eHealth has suggested to state-based Exchanges to alleviate state concerns about biased consumer displays.[4]

---

[3] Consumers' preference for selection from among the first screen of search results is well documented. See report by Consumers Union and Kleimann Communications, *Choice Architecture: Design Decisions that Affect Consumers' Health Plan Choices*, July 2012, http://consumersunion.org/research/report-choice-architecture-design-decisions-that-affect-consumers-health-plan-choices/.

[4] Personal conversation between Lynn Quincy (Consumers Union) and Gary Lauer, CEO of eHealth, May 23, 2013. Lanny Davis and Eleanor McManus also in attendance.

An I-frame embeds another HTML page into the current page. In this case, the web-broker "frame" would surround and display Exchange website content, including premium rates, alleviating the concerns about proprietary, intermediate ranking factors. Each page has its own history and content. Depending on how it is used, the I-frame approach can be consumer-friendly. However, if not designed appropriately, I-frames can be used to inappropriately steer consumers, for example by:

- Embedding other links in the frame, with design elements that seek to have consumers click on the embedded HTML, redirecting them to new content.
- Directing them to the phone instead of web.

If I-frames are used, the design should incorporate consumer protections to ensure that steering tactics are not permissible. Thus, if the proposed regulations do not revert to the earlier rule, HHS should require that web-brokers use of I-frames in such a manner that their displays of QHPs provide consumers with complete information. Appropriate consumer protections should be included, such as requiring the prominent display of a link that allows the consumer to click through and use the Exchange website without the frame.

> **CU Recommendation**: Revise §155.220(c)(3)(i) to read: "Disclose and display all QHP information provided by the Exchange ~~or directly by QHP issuers~~ consistent with the requirements of §155.205(b)(1) and §155.205(c), by utilizing I-Frame technologies to ensure that all QHP information is provided to consumers and prominently displays a Web link to the Exchange website."

While we do not recommend that HHS continue with the proposed rule with respect to §155.220(c)(3), the language as drafted must be made stronger, as noted below.

> **CU Recommendation:** We recommend the proposed language be altered to read: "Disclose and display all QHP information provided by the Exchange or directly by QHP issuers consistent with the requirements of §155.205(b)(1) and §155.205(c), and prominently display a Web link to the Exchange Web site."

Under this scenario, we further recommend that new language should be added to the effect that QHPs have the ability and right to insist that all their information be passed through to web-based brokers so that they are displayed on an equal basis, thereby not allowing the Exchange and web-based brokers to block such displays.

> **CU Recommendation:** Add new section (c)(3)(viii) to read: "Permit all QHP issuers participating in the Exchange to release their information required by §155.205(b)(1) and §155.205(c) to be passed through and displayed on the Internet Web site of the agent or broker."

If QHP issuers don't have this ability, a failure of the Exchange to pass through their data could result in an obligation to contract with the web-based broker in order to receive equal treatment in the web-based broker display.

If neither of the two approaches recommended above are adopted, we urge HHS to reassess the value of allowing web-based brokers to display Exchange products, given the degradation in the consumer's experience.

> **CU Recommendation:** If HHS cannot find a method of having web-based brokers display all data for all QHPs (as per the earlier rule), we recommend that the federally-facilitated Exchanges not use web-based brokers to sell these products in the first year.

In addition, HHS solicits comments on how to monitor compliance with the requirement that web-brokers display QHP information *received by an Exchange or QHP issuers* in a manner consistent with the QHP information displayed on an Exchange website. Consumers Union believes that it is difficult at this stage to anticipate how web-based brokers will use any latitude provided by the final rule.

We recommend that the final rule include a dedicated monitoring effort, led by HHS during the 2013-2014 open enrollment period, including requirement of a publicly available report published mid-year the first year and each year thereafter. This effort should include results from the QHP displays used by web-based brokers in states with state-based Exchanges, so the impact of differences in rules can be contrasted. Well understood principles of choice architecture should be applied so that inappropriate steering can be identified. An example of inappropriate steering would be to list all plans, but on the first page of results only list those plans that pay commissions, and to require many clicks to see the other plans.[5]

> **CU Recommendation:** Add new section §155.220(f) that establishes HHS monitoring standards and time frames, including a public report to be published no later than June 30, 2014 and annually each year thereafter.

HHS proposed to address situations where the web-broker is unable to display certain QHP information identified in §155.205(b)(1) by requiring the web-broker must display a link to the Exchange website so the consumer may obtain the additional information.

Consumers Union recommends a stronger approach, namely:

> **CU Recommendation:**
> - A link to the state Marketplace should always be prominently displayed (regardless of how much QHP data the web-broker has; see comment on proposed new paragraph (c)(3)(vii) below).
> - While we do not support incomplete displays of QHP information by web-brokers, if the rule permits this outcome, we recommend that the proposed rule be strengthened to require a link to the state Marketplace be embedded

[5] See Consumers Union, *Recommended Consumer Protections for Web-based Agents and Brokers offering Exchange Coverage*, September 2012.

right where the missing information would be located (see sample table above).

HHS invites comments on whether or not to remove §155.220(c)(3)(ii), which requires web-brokers to provide consumers with the ability to view all QHPs offered through the Exchange.

Consumers Union strongly agrees with CMS's decision to keep this requirement so that the consumer would be aware of all available QHP options, even if some of the specific plan details may not be available on the web-broker's internet website.

Consumers Union believes that web-brokers add value only when consumers can see all the QHP options, displayed together and in the same order as the default sort on the Exchange, ideally with complete data for each plan.

**We strongly support the idea of the proposed new paragraph (c)(3)(vii),** which would require web-brokers' internet websites *in an FFE* to prominently display language notifying consumers of certain facts about the web-based broker site. However, we recommend language revisions to make the intent clearer to consumers. Moreover, we do not see how consumers would benefit by requiring display information that the web-broker has entered into an agreement with HHS, and, in fact, think it could convey unjustified credibility that could mask potential shortcomings of these websites. Instead, we suggest specific reference to compliance with federal display standards and a route to reporting noncompliance.

> **CU Recommendation:** Section 155.220(c)(3)(vii) should be revised to read: "For the Federally-facilitated Exchange, prominently display language notifying consumers that (a) this [Web-broker's] Web site is neither the FFE nor the Marketplace Web site for [state.]; (b) the Web-broker's Web site [does/does not] display all health plan data available on the Marketplace Web site for [state], click here [state Marketplace] to see all health plan data; and (c) this agent or broker has agreed to comply with federal standards governing the display of Marketplace health plans; and (d) provide the option for consumers to email or phone HHS if the site appears to violate the basic principles of complete and unbiased display of QHP health plans."

HHS also asks for comments on allowing web-brokers to enter into arrangements with *other agents and brokers* under which those agents and brokers would be able to enroll qualified individuals in an FFE through the web-broker's internet website.

We share HHS's concern that these "other" agents and brokers would not have entered into an agreement with the Exchange either as a web-based broker or as an independent broker registered with the Exchange. Given broker dismay over the absence of a broker portal, we speculate that brokers may flock to such web-broker sites, particularly if web-broker sites are allowed to display premium rate information for

only a partial list of QHPs. If those QHPs are the high commission plans, then these "other" brokers would have an incentive to limit their clients' view to just those plans.

> **CU Recommendation:** We recommend prohibiting the use of web-based broker websites by "other" agents and brokers. To do otherwise would provide a means of circumventing the rules surrounding brokers and exchange plans.

In addition, we urge CMS to include in Section 155.220(c)(3) a prohibition on web-based brokers collecting and storing any data that is not solely for Exchange enrollment purposes. For example, a web-based broker may use an internet cookie to collect information on a potential enrollee. While this facilitates enrollment for a customer who starts an application, pauses and then returns to complete it; there is a risk that this tracking could be used by an issuer with multiple business lines to market other goods or services to potential enrollees.

> **CU Recommendation:** Prohibit web-based brokers from gathering or storing data beyond that necessary for Exchange eligibility and enrollment via "cookies" or other tracking tools. Also, bar web-based brokers from storing or using information gathered from consumers in the application process for marketing products.

**Standards for Agent and Broker Termination in an FFE -- § 155.220(f) and (g)**

Since the Affordable Care Act makes clear that data collected by an Exchange be used for Exchange purposes only, when an agreement between an FFE and an agent or broker is terminated, such termination also ends an agent's or broker's authority to access, use, or disclose any data collected from applicants. The proposed regulation does not include language requiring agents and brokers to securely destroy the data collected from any applicant (or potential applicant) prior to termination of the agreement, so we suggest that the final rule do so.

> **CU Recommendation**: We urge CMS, in the final rule, to require agents or brokers whose agreements with FFEs have been terminated (either voluntarily or for noncompliance) to destroy applicant data in a manner consistent with NIST destruction standards.

Consumers Union supports the proposal that FFE agreements should be terminated between HHS and agents or brokers if HHS deems a specific finding of noncompliance or a pattern of non-compliance by the agent or broker sufficiently severe. We also support the enumerated laws violations of which may constitute a finding of non-compliance, including 155.220 standards and other state and federal laws applicable to agents and brokers. We suggest adding another category to capture non-compliance with deceptive marketing statutes. We also support the explicit requirement in 155.220(f) binding agents and brokers to compliance with Exchange privacy and security regulations even *after* the termination of any agreement between an agent or broker and the FFE.

**CU Recommendation**: Add the following new sub-section 155.220(g)(2)(v): "Any State or Federal unfair and deceptive practices law."

**Oversight and Monitoring of Privacy and Security-- §155.280**

Consumers Union commends the introduction of strict breach standards meant to protect consumers from unauthorized releases of sensitive information. The definitions for breach and incident cover multiple avenues and vehicles for compromising the security of patient data. We also support establishing a time frame for reporting privacy and security incidents and breaches by the FFE, non-Exchange entities associated with the FFE, and State Exchanges. We think prompt notice to HHS is wise, but one hour may be insufficient time to assess whether suspicious activity is actually a breach or incident.

> **CU Recommendation:** We recommend that §155.280(c)(3) be amended as follows: "Federally-facilitated Exchanges, non-Exchange entities associated with the Federally-facilitated Exchange, and State Exchanges must report all suspected privacy and security incidences and breaches to HHS within one (1) hour of discovering the suspected incident or breach."

Also, we see a gap in regard to non-Exchange entities associated with a State Exchange. As drafted, the proposed regulations have no clear time frame for reporting suspected privacy and security breaches and incidents by such entities t the State Exchange. The provision should be amended to include a prompt time standard like that imposed on the State Exchange for reporting suspected breaches to HHS.

> **CU Recommendation:** We recommend that §155.280(c)(3) be amended as follows: "A non-Exchange entity associated with a State Exchange must report all suspected privacy and security incidents and breaches to the State Exchange with which they are associated within one (1) hour of suspecting an incident or breach."

**Failure to reduce enrollee's premiums to account for APTCs-- §155.340(h)**

Consumers Union supports the addition of this proposed rule regarding the proper processing of excess premium payments. The new provision creates strong consumer protections to ensure that Exchanges refund excess money collected due to an improper application of the APTC calculation.

**Direct Enrollment with the QHP Issuer – §§155.415, and 156.1230**

In comments to the October 2012 proposed regulations, Consumers Union articulated our concerns regarding QHP issuer involvement with the application and eligibility process. The final regulations, issued in March 2012, created strong consumer

protections by establishing final rules that ensured confidential applicant information was not shared with issuers. These proposed rules dilute the important consumer protections in the final March 2012 regulations. We reiterate here our concerns about allowing QHP issuers to help with eligibility applications, unless there are sufficient safeguards.

Many of the data elements needed for the *application process*, including immigration status and income data are not necessary for the plan enrollment process. While we are in a new world that prohibits medical underwriting and discrimination based on health status or ability to pay, the proposed provisions that allow issuers access to eligibility information create the potential for cherry-picking or adverse selection. For example, when a QHP issuer learns that a low-income individual is applying for coverage, the issuer may encourage the applicant to seek coverage from an alternate QHP for fear of inability to pay premiums. QHP issuers should only be allowed to collect and store data that is needed for their enrollment role.

If the proposed regulations are preserved, the QHP issuer is standing in the shoes of the Exchange and should be held to the same standards of privacy and security to which the Exchange is held. If HHS allows QHP issuers to have access to private consumer information not necessary for enrollment, the regulations need to ensure that the information learned by the issuer during the application process is not stored in the issuer's own database systems, but can only be stored in the FFE or a State Exchange.

In this manner, the QHP issuer will only be able to access the same level of consumer information that would be given to it had the consumer applied for insurance affordability programs and enrolled directly through the Exchange. In addition, to ensure that existing enrollees' health status does not become a basis for steering if plans help such enrollees transition into Exchange products and subsidies - a worthy endeavor -, the regulations should require that QHP issuers have firewalls in place that ensure that staff assisting in the application process are prevented from having access to claims data. Further, for consistency, the training and certification requirement for QHP employees should, at a minimum, be the same as required for navigators in that state, including using the same third party entity, if any, as for training navigators .

> **CU Recommendation**: Amend §155.415(a) to include the following additional language: "(i) At no time during the application process shall any personal information supplied by the applicant, other than information necessary for enrollment, be entered into the QHP issuer database; (ii) Issuer customer service representatives shall not have access to the claims data of the issuer; and (iii) Customer service representatives shall be held to the same training and certification requirements that are required in the relevant state or FFE Navigator program."
>
> Amend §156.1230(a)(2) to include the following additional language: "(iv) At no time during the application process shall any personal information supplied by the applicant, other than information necessary for enrollment, be entered into

the QHP issuer database; (v) Issuer customer service representatives shall not have access to the claims data of the issuer; and (vi) Customer service representatives shall be held to the same training and certification requirements that are required in the relevant state or FFE Navigator program."

Consumers Union also recommends that plan-based enrollers meet the same standards as other assisters, such as Navigators and certified/registered agents and brokers, in the relevant Exchange, either FFE, State Partnership, or state-based Exchange. In order to maintain quality standards for application assistance practices and to ensure consistency, all persons assisting in enrollment should be certified through the Exchange.

**CU Recommendation:** Under §156.1230(a)(2)(i) should be revised to state, " "Receives training and certification from the FFE, State Partnership, or State Exchange on QHP options and insurance affordability programs, eligibility, and benefits rules and regulations."

Regulatory language should be added to these provisions to ensure that issuers are held responsible for the conduct of contractors and any misconduct by the contractor should be grounds for suspension of QHP certification.

**CU Recommendation:** Under §156.1230 an additional provision should be added as (c) that states that: "QHP issuers are responsible for any fraud, misconduct, or other illegal activity of their consumer service representatives while assisting individuals in the manner permitted by (a)(2) of this section."

HHS should require that QHP issuers use HHS pre-approved universal disclaimer language stating that there are other coverage options in the Marketplace and not all options are displayed.

**CU Recommendation:** Amend §156.1230(a)(1)(iv) to state that "The QHP issuer informs all applicants of the availability of other QHP products offered through the Exchange through an HHS-approved universal disclaimer and displays the Web link to ~~or~~ and describes how to access the Exchange Web site."

Finally, we suggest that HHS develop guidance concerning plan customer service representatives assisting consumers who end up ineligible for Exchange products, but who are eligible for Medicaid, CHIP, or other non-Exchange insurance affordability programs. We look to HHS to develop policies and standards that ensure robust, non-discriminatory service for such consumers, such as requiring "warm-handoffs" to the relevant agency, when QHP issuers initiate applications only to discover mid-stream that the applicant is likely eligible for non-Exchange insurance affordability programs.

**Special enrollment--§155.420(d)(10)**

Consumers Union commends HHS for the addition of this provision which clarifies the circumstances for a special enrollment period for consumers in the individual market who did not have the appropriate QHP enrollment due to misconduct on the part of a non-Exchange entity providing enrollment assistance. The new provision ensures, as noted in the preamble, that consumers are protected when, based on no fault of their own, they are enrolled incorrectly or inappropriately in coverage such that they are not enrolled in QHP coverage as desired, are not enrolled in their selected QHP, or have been determined eligible for but are not receiving advance payments of the premium tax credit or cost-sharing reduction. This is an extremely important provision that should be retained in the final regulations.

Non-Exchange entities will be performing enrollment activities, including in some cases by enrolling consumers directly in QHPs. Consumers would be harmed if they fail to enroll in a health plan, or are enrolled in a QHP they did not select, as a result of misconduct on the part of a non-Exchange entity. Consumers would also be seriously harmed if they are eligible for, but not receiving advance payments of the premium tax credit or cost-sharing reductions, as a result of misconduct on the part of a non-Exchange entity.

This special enrollment category exists currently (existing section 155.420(d)(4)) when the misconduct is by the Exchange. Since other non-Exchange entities will also be allowed to directly enroll in QHPs, the same role as the Exchange, the proposed provision is extremely important to ensure that all enrollees have similar protections against these kinds of harms. We strongly urge that it be retained in the final regulations.

**Enrollment Process for Qualified Individuals-- §156.1240**

Consumers Union strongly supports the addition of access requirements for persons who do not have bank accounts or credit cards.

We appreciate the recognition in the preamble of the minimum payment options necessary to protect consumers who use a range of payment methods, including those who do not or cannot use banks or credit cards. We urge adding language similar to that into the regulation:

> **CU Recommendation:** (a)(2) should be amended to read: "Offer method of payment options that do not discriminate against individuals without bank accounts or credit cards, including, but not limited to, cash, paper checks, cashier's checks, money orders, reloadable prepaid debit cards, and other alternative payment methods so that individuals without a bank account will have readily available options for making monthly premium payments."

Since many low-income households rely heavily on cash transactions, we recommend that QHP issuers and Exchanges be required to accept cash, as suggested by the recommendation above. We recognize that not all QHP issuers or Exchanges will be able to physically accept all of the required forms of payment. QHPs can meet the standard by having an arrangement with a payment provider that will allow consumers to use most forms of payment, including cash payments, where the payment provider transmits payments electronically to the insurance issuer. This provider would make cash payment possible by allowing low-income persons to convert cash into an electronic payment at a neighborhood location. We are aware of a number of state Children's Health Insurance Programs (CHIP) that have utilized such payment systems to enable enrollees to pay premiums easily and at no additional cost.

Consumers Union suggests an additional provision to §156.1240(a) that requires QHP issuers to accept payment through payment providers that meet certain consumer protection standards:

> **CU Recommendation:** Add new section (a)(3) that states: "QHP issuers may meet the requirements in (a)(2) by utilizing a no-fee alternative cash payment system. Such payment providers used by QHPs must include:
>
> (i) Sites open during convenient hours, such as evenings and weekends; and
> (ii)) Compliance with privacy and security protections, as required under the ACA.[6]
>
> (iii) In addition, QHPs should ensure that a sufficient number of alternative cash payment system sites are:
> (a) Located in low-income communities;
> (b) Accessible to public transportation;
> (c) Offer services in a variety of threshold languages (and that provide information about how to get help in other languages); and
> (d) Able to confirm payments through a variety of different methods (paper receipts, e-mail confirmation, etc.).

We look forward to seeing revised rules and working with HHS and others to ensure that the FFE and State Exchanges provide robust and comprehensive protections in the best interest of consumers.

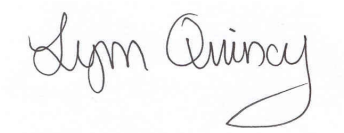
Sincerely,

Elizabeth Imholz, Special Projects Director

---

[6] For further information about these recommendations, please See *Consumers Union Report, Fair Premium Payment Policies and Practices in Covered California* (June 20, 2013) available at http://consumersunion.org/wp-content/uploads/2013/07/fair_premium_practices_CA_2013.pdf

Julie Silas, Senior Attorney



Lynn Quincy, Senior Policy Analyst