November 6, 2015

BY ELECTRONIC DELIVERY

Mr. Andy Slavvit, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services,
Attention: CMS 9937-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017

Dear Acting Administrator Slavvit:

Connect for Health Colorado greatly appreciates the opportunity provided by the Centers for Medicare & Medicaid Services ("CMS") to comment on the proposed rule, "HHS Notice of Benefit and Payment Parameters for 2017." The specific provisions we request clarification for, or which would have a particular impact on the Connect for Health Colorado, are listed below in the order in which they are to be encoded.

I. Background

Connect for Health Colorado, the state-based health insurance marketplace ("SBM") for Colorado, is a non-profit entity established by Colorado state law and the Patient Protection and Affordable Care Act ("ACA"). The organization, legally known as the Colorado Health Benefit Exchange, provides access to qualified health plans and financial assistance in the form of advance premium tax credits and cost share reductions for qualified individuals. As such, Connect for Health Colorado is directly regulated and impacted by the proposed rules, especially those parts of proposed rule which are encoded within Part 155. Additionally, while not directly governing Connect for Health Colorado, we request clarification on one provision within Part 156.

II. Specific Comments

A. Standards Applicable to Navigators Under §§155.210

Within §155.210(e)(9), CMS proposes to require navigators to provide additional assistance, "including post-enrollment assistance." Among such post-enrollment assistance would be aiding individuals in filing appeals of eligibility, applying for an exemption and helping consumers to understand basic concepts related to health coverage and how to use it. In principle, Connect for Health Colorado supports the goals of the proposed changes. However, experience has shown that such post enrollment assistance may turn into extended case management or patient advocacy and would require considerable additional training and expenditures unless the rules are sufficiently specific. Such post enrollment assistance could easily become administratively burdensome without additional funding for necessary staffing and training.

Currently, Colorado's Navigator sites assist applicants in filing appeals for eligibility. Connect for Health Colorado supports this role for Navigators as many Colorado Navigators have greatly aided applicants in submitting appeal requests. For persons unfamiliar with administrative appeal proceedings or the tenets of the ACA, having a navigator explain what issues are properly appealable and whether more expeditious methods of correcting account issues are available had been effective.

On the proposed requirement for Navigators to assist consumers in applying for exemptions from the individual shared responsibility payment, Connect for Health Colorado requests clarification that such requirements would be limited to providing information on how an individual would apply for the exemptions. We do not believe subsequent actions, such as having a Navigator inquire as to the status of the application for the exemption, should be required. We also support the limitations proposed in the preamble to the proposed rule that assistance on appeals of exemption applications be a restricted to those denied coverage or financial assistance. Additionally, we request that, since exemptions are to be processed by federal agencies in the present and future years, some guidance be produced that would account for any particular issues that may apply to Navigators operating under an SBM.

On the proposal to require Navigators to help consumers with the premium tax credit reconciliation process, Connect for Health Colorado supports the provision of high-level 1095 information. However, Connect for Health Colorado strongly encourages CMS to adopt the proposal that would require Navigators to give a disclaimer that they cannot provide tax advice. We feel that if such a disclaimer is not provided, Navigator sites may be exposed to unnecessary liability. For similar reasons, we support the provision in §155.210(e)(9)(v) that would require them to refer consumer to licensed tax advisers.

Another proposal within the preamble suggests that there should be five elements to Navigator's education efforts. Among those elements are requirements to educate consumers on:

> (3) how to identify in-network providers to make and prepare for an appointment with a provider; (4) how the consumer's coverage addresses steps that often are taken after an appointment with a provider such as making a follow-up appointment and filling a prescription; and (5) the right to coverage of certain preventative health services without cost sharing.

The preamble then states that, “We anticipate that this assistance would vary depending on each consumer’s needs and goals.” Connect for Health Colorado requests clarification on these elements as well as the last sentence. Specifically, we request clarification as to whether these elements pertain more to general education about health coverage or whether the Navigators would be expected to assist individuals in activities such as making appointments or filling prescriptions. We believe the latter would be overly burdensome.

One last issue in the preamble pertains to an interpretation of 155.210(e)(4). That is, CMS states that they interpret the rule requiring “referrals for certain post-enrollment issues to mean that Navigators may help consumers obtain assistance with coverage claim denials.” Connect for Health Colorado seeks clarification as to whether this interpretation would require Navigators to do more than provide information about how a consumer may dispute coverage claim denials. A more expansive interpretation could both put the Navigator in the position of acting as a patient advocate with the insurance carrier and instill potential bias against a particular carrier if a Navigator happens to participate in a disproportionate number of coverage claim denials with that carrier.

B. Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (155.220).

In §155.220(c), CMS proposes to require Agents and Brokers who assist with enrollment through an Exchange to “ensure completion of an eligibility verification and enrollment application through the Exchange as described in §155.405.” Connect for Health Colorado requests clarification as to whether an exception would apply where an Agent or Broker is able to demonstrate that a technological error or defect prevented completion.

C. Standards Applicable to Certified Application Counselors (§155.225)

Connect for Health Colorado supports the proposed rule that clarifies that states may “establish reporting standards as they determine appropriate” as applied to certified application counselors (“CACs”). However, we seek clarification that the state is also able to establish the frequency and time periods of the reports. Connect for Health Colorado would like to note that SBMs, depending on population and size of the Exchange service area may have hundreds of CAC sites. With such high numbers, even if the Exchange can set the reporting standards and frequency, having staff monitor the reports will result in significant additional costs.

D. Eligibility process (§155.310(h))

CMS has proposed a change to the rule requiring the Exchange to provide notice to an applicable large employer of an employee’s eligibility for financial assistance. The change would only require notification to the employer if the employee enrolls in a plan (rather than is found eligible for assistance). Connect for Health Colorado strongly supports this change as it will reduce the administrative burden of SBMs. We also support the proposed option to allow an Exchange to choose the manner in which they notify an employer, either sending individual notices for each employee or sending one notice per employer notifying the employer of multiple employee’s eligibility.

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E. Verification Process Related to Eligibility for Insurance Affordability Programs (§155.320)

CMS has proposed a change to §155.320(c)(3)(vi) to allow for an Exchange to "set a reasonable threshold […] where the applicant's attestation of projected annual household income is lower than income data received from trusted data sources." Connect for Health Colorado supports this proposal. Allowing an Exchange to increase the threshold to better fit the needs of its particular customer demographics would also lessen administrative burdens on the Exchange.

F. Medicare Notices

Within the Preamble to the proposed rule, CMS requests comment on possible methods of providing notice that an enrollee may be eligible for Medicare. Connect for Health Colorado only seeks clarification as to whether CMS intends to implement standard notification requirements that would be applicable to SBMs.

G. Enrollment of Qualified Individuals into QHPs (§155.400)

Regarding the proposal to set the deadline for a "binder payment related to prospective coverage with a prospective effective date, […] no earlier than the coverage effective date and no later than 30 calendar days from the date the issuer receives the enrollment transaction or the coverage effective date, whichever is later." Connect for Health Colorado asks for clarification as to whether the carrier is required to institute a uniform requirement on when the binder payment is due or whether the carrier is allowed to set a date within the given window on a case by case basis.

H. Annual Open Enrollment Period (§155.410)

For the request for comments on the 2018 open enrollment period, Connect for Health Colorado suggests an open enrollment period beginning October 1 and running through December 15th of the same year. We believe such an open enrollment period would be of sufficient duration and would have the added benefit of more closely aligning with the annual Medicare open enrollment period. Ending the open enrollment period prior to the benefit year would also lessen some of the administrative burdens on carriers.

I. Appeals Coordination (§155.510)

Within §155.510(a)(1), CMS has proposed a revision that would allow the appeals entity to ask for information that may have already been provided, either to the Exchange or an entity administering Medicaid. Connect for Health Colorado strongly supports this provision as experience has shown that consumers may not send information to the right location or an actual document may become irretrievable for technological reasons. In many cases the individual consumer will volunteer to provide the needed information again, but allowing the appeals entity to request the needed information would expedite the appeals process.

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J. Eligibility Determination Process for SHOP (§155.715)

CMS has proposed amending §155.715(g)(1) to rescind the requirement that if an employer exits a Small Business Health Options Program ("SHOP"), that the associated coverage for the individual employees would also terminate. Instead, CMS proposes that an employer who decides to leave a SHOP would have the coverage for the individual employees continue.

Connect for Health Colorado opposes this proposed change and also requests additional clarification. As described, such a change would likely introduce unneeded complexity into employer and carrier interactions, particularly in the case where an employer has provided a choice in coverage to its employees. As written, it is not clear how a transition would occur in terms of both data and payment methods. If an employer who has chosen to offer multiple options to carriers exits the SHOP program they would likely need to contact each carrier and make separate payment arrangements without any material benefit. Additionally, if, as with the individual market, the SHOP is to act as the system of record for enrollments, the ability for an employer to continue the same coverage outside of the SHOP would likely create an incentive (as we have seen with customers attempting to directly contact carriers in the individual market) for an employer to attempt to make changes to enrollment directly with the carrier. Such changes create disparities in the information between the SHOP and the employer, creating unnecessary confusion and unduly burdening both entities.

K. Enrollment Process for Qualified Individuals (§156.265)

Within 45 CFR §156.265, HHS is considering options under which an applicant could remain on the QHP issuer's website to complete an application and enroll in QHP coverage. Further, the QHP issuer's website could obtain eligibility information from the Exchange to support the selection and enrollment in a QHP with financial assistance from the Exchange.

Connect for Health Colorado requests clarity regarding the scope of this consideration. It is not clear from the commentary or the proposed regulatory language whether this would apply to State-based Exchanges. The proposed regulatory language references the use of the "FFE single streamline application." However, this proposed regulatory language is positioned to be inserted within 45 CFR §156.265(b)(2)(ii). The larger requirement of 45 CFR §156.265(b)(2) regarding enrollment through the Exchange for the individual market does not generally contain limitations to the FFE. Consequently, the intended scope of this consideration is ambiguous.

If HHS intends for this proposal to apply to State-based Exchanges, Connect for Health Colorado interprets this proposal to be optional. This interpretation is based upon the common interpretation of the conjunction "or" used after 45 CFR §156.265(b)(2)(i), which implies that in the larger scope of 45 CFR §156.265(b)(2), QHP issuers must fulfil one of the two requirements in order to be compliant. That is, either direct the individual to the Exchange to initiate the enrollment, or the QHP issuer may pursue developing functionality with the Exchange to facilitate this proposal.

While Connect for Health Colorado supports holistic improvements to the customer experience, it would object to any requirement to develop and support this functionality in the imminent future. As a

State-based Exchange with multiple autonomous issuers, developing functionality in a short-term to support this proposal with multiple and diverse issuer systems would be overly burdensome. It would divert resources from addressing and improving core system functionality, and would potentially require financial resources for which Connect for Health Colorado has not budgeted.

III. Conclusion

Connect for Health Colorado supports CMS in their efforts to refine the Patient Protection and Affordable Care Act implementing regulations in a manner that will increase access to health coverage. We again thank you for the opportunity to comment and believe that with the requested clarifications and changes, Connect for Health Colorado will be better positioned to assist Coloradans in attaining health coverage.

Regards,

Connect for Health Colorado Staff

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