December 21, 2015

VIA ELECTRONIC SUBMISSION Tracking number 1jz-8mxx-xffz

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-9937-P

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

Dear Sir/Madam:

The Center for Public Policy Priorities (CPPP), Light and Salt Association, Texas Association of Community Health Centers, and CentroMed Medical Clinics appreciate the opportunity to comment on CMS-9937-P, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017" (hereinafter referred to as "the proposed rule").

CPPP is an independent public policy organization established in 1985 that uses data and analysis to advocate for solutions that enable Texans of all backgrounds to reach their full potential. Improving access to health care for Texans has been at the core of our mission and activities since our founding.

Light and Salt is a current Navigator grantee. CentroMed Medical Clinics are federally qualified health centers that employ Certified Application Counselors. The Texas Association of Community Health Centers is a private, non-profit membership association that represents safety-net health care providers in the state of Texas many of which provide application assistance and employ Certified Application Counselors and Navigators.

General Comments

The proposed regulations include many important steps forward for consumers. We applaud CMS for strengthening consumer protections in the proposed regulations, especially by expanding services required to be provided by Navigator programs, improving the annual auto-re-enrollment process for QHPs in the Federally facilitated Exchange (FFE), allowing additional flexibility for Exchanges to improve income verification processes, streamlining the exemption process for consumers living in states that have not expanded Medicaid to the new adult population, and looking to improve notices to consumers regarding Medicare eligibility. In preparation for the submission of these comments, CPPP gathered together leadership of Navigator and Certified Application Counselor (CAC) organizations from across the state of Texas to discuss the impact of the proposed rules on these organizations and the consumers they serve. These comments reflect the general consensus of this discussion. We believe that

Navigators and CACs can provide an informed perspective on many of the proposed rules given their day-to-day interaction with consumers. We also feel the voice of these organizations should be considered when regulating their activities. We appreciate the opportunity to provide comments on these rules.

§ 155.210 – Navigator Program Standards

1. Overall, we support the proposed expansion to the role of Navigators and Navigator organizations to include outreach and education to vulnerable populations and assistance with post enrollment issues including education about the tax reconciliation process, assistance with filing appeals and exemptions to the shared responsibility payment, and assistance with health insurance literacy needs. We are supportive of these rules because they are codifying services that many, if not most, Navigators organizations are already providing to consumers in their communities. Formalizing these activities into regulation as proposed will more clearly define the extent and complexity of the Navigator role and ensure that individuals and organizations identified as Navigators provide comprehensive and consistent services.

   However, with any formal extension of the Navigator role, CMS should also consider the potential strain on Navigator resources and time and the burden of any additional required training. This year the funding for Navigators was announced on September 2, 2015. This provided new Navigator grantees less than two months to hire, train, and certify Navigator staff before the beginning of the open enrollment period for plan year 2016. In Texas, under state statute, Navigators are required to take an additional twenty hours of state-specific training on top of the approximately twenty hours of training required by CMS. In addition, Texas statute requires Navigators to submit to a background check and finger printing. Given the administrative complexity of certifying an organization and staff as Navigators any additional formal extension of the role of Navigators must be done in a manner that thoughtfully considers the need for additional time between the announcement of the Navigator grantees and the beginning of the following open enrollment. We acknowledge that the change to the Navigator funding structure from one-year grants to the current three-year grant reduces this consideration to only apply every third year, assuming the current funding structure continues. Also, the amount of funding made available to Navigators should be adjusted appropriately given the extension of the role of the Navigator organizations. In short, for these changes to be effectively implemented by Navigators and for them to have a meaningful impact on consumers, they must be accompanied by the necessary additional time and resources through the grant process.

2. Overall, we support the proposed changes to require Navigators to provide targeted assistance to serve underserved and/or vulnerable populations within an Exchange service area. We feel that Navigators are uniquely positioned to serve these populations because they are currently required to have expertise in the needs of these populations, and many are from community and consumer-focused nonprofits who have strong ties to and pre-existing relationships with these communities. As a result, we feel that Navigators are strongly positioned to meet this requirement and, as stated above, many organizations are already

providing this service to their communities. However, we request that CMS further explain how Navigators are expected to "target" or "focus" their work on these populations, since they are also required to assist any consumer seeking assistance.
In particular, we urge CMS to do the following:

a. Define what activities or strategies they view as "targeting" a particular population;
b. Provide guidance on how Navigators can or should balance the responsibility to assist other underserved or vulnerable populations while also assisting all other consumers seeking assistance;
c. Provide Navigators the opportunity to give input to the Exchange on which populations or communities they feel should be a target priority, as well as to propose additional populations.

3. We support the new requirement for Navigators to provide information and assistance with exemptions to the individual shared responsibility payment, and would support a requirement for Navigators to provide a verbal or written disclaimer to consumers that Navigators are not tax advisers and cannot provide tax advice prior to providing any such assistance. Many Navigator organizations already provide consumers with this type of disclaimer; some do this verbally, while others have this as part of their written consumer consent form.

   CMS requested specific comment on whether it would be appropriate to limit the requirement for Navigators to provide assistance with exemptions to only consumers who had applied for or had been denied assistance, in an effort to reduce the resource constraint on Navigator organizations. We feel any such limitation would be more burdensome to resources not less. For example, in a state such as Texas, many clients are obviously ineligible for financial assistance because Texas has chosen not to expand Medicaid to the new adult population. In this scenario, it is often faster to simply provide assistance with the application for the appropriate exemption rather than first applying for assistance for which the client is obviously ineligible. Furthermore, it is our strong belief that any consumer who seeks assistance in applying for an exemption should be provided such assistance and that Navigators should treat all consumers equally.

4. We also support the requirement that Navigators provide information regarding the tax credit reconciliation process but request further support from CMS in helping Navigators understand what level and type of assistance that is being required of them in the proposed rule. We agree with CMS that Navigators have expertise related to Exchange eligibility and enrollment rules that uniquely qualify them to help consumers with the reconciliation process. However, we are also aware of the resource limitations that Navigators and their funding agencies may face, and are concerned about the amount of time that may be required for Navigators to familiarize themselves with all of the IRS resources available, as well as all of the tax law, legal aid, and VITA agencies that may be available in their area. To better help Navigators meet this new requirement, we suggest that CMS incorporate new modules regarding tax credit reconciliation and referrals to tax preparation services into the annual assister training and require both new and returning Navigators to complete the modules, so that Navigators can be provided with a pre-dedicated, mandatory time in which they can build the level of knowledge needed to assist consumers.

§155.225 – Certified Application Counselors Standards

1. While we are generally supportive of the collection of performance data to measure the extent of the services provided by Certified Application Counselors (CACs), we strongly encourage CMS to be thoughtful regarding the additional burden this may place on CAC organizations and personnel. Any requirement to provide data should not be duplicative of data already being provided by CAC organizations and Exchanges should not require CAC organizations to provide data to which the Exchanges already have access.

    a. We believe some of the data points required under the proposed rule, specifically the number of clients who received application assistance and the number of CACs certified by the organization, could be determined using information already available to Federally-facilitated Exchanges (FFE) and, therefore, CACs should not be required to provide such data again. The FFE requires CACs to provide their CAC identification number and organization identification number on every application submitted to Healthcare.gov for which the CAC provided assistance. This is also true of the single-streamlined application submitted to the Texas Medicaid agency. Also, CMS should have access to the number of CACs an organization has certified through the online training system already in place.

    b. Finally, CMS should coordinate with HRSA on performance, registration, and reporting requirements that affect Certified Application Counselors at Federally-qualified Health Centers (FQHCs). In Texas, most FQHCs receive grant funding from HRSA to serve as CACs. These grant funds come with numerous conditions, around both performance and reporting. In general, we request that CMS work with HRSA when finalizing these rules to ensure that no requirements in this rule contradict or are duplicative of requirements under the HRSA CAC grants. For example, proposed §155.225(b)(1) states that each CAC-designated organization must provide the Exchange with information and data related to the number and performance of its CACs and the assistance they provide. Since health centers report this type of data to HRSA, we request that CMS and HRSA work collaboratively to align these requirements, thereby ensuring that health centers are not subject to duplicative or overly burdensome reporting demands.

§ 155.320(c)(3)(vi) – Alternate income verification process

We strongly support CMS' proposal to allow the Exchange to set a reasonable threshold of no less than 10 percent, for the maximum percentage by which an applicant's attestation of projected annual household income may be lower than the income data received by the Exchange from trusted data sources. Under this standard, an applicant would not be required to enter the alternate verification process to support a projected income decrease when the variation between attested income and income observed by the Exchange is less than 10%. We believe this additional flexibility will allow Exchanges to set thresholds that make more sense for low and moderate-income consumers who often have income that fluctuates from year to year.

§155.335 - Annual Eligibility Redetermination

1. We applaud CMS for considering ways to minimize potential disruptions of enrollee eligibility with continuous enrollment in silver-level plans with cost-sharing reductions, if that plan is no longer available for reenrollment and if the enrollee's current product no longer includes a silver-level plan. We support reenrolling consumers in a silver-level plan offered by the same issuer in a product that is most similar to the consumer's previous product. We agree with CMS that transitioning enrollees in this manner is an efficient way to reenroll consumers and is also protective of their health needs and financial situations.

2. We share CMS's interest in protecting consumers from being automatically enrolled in plans with substantially higher premiums. However, while we know that low-premium plans are important to many consumers, we are concerned that defaulting to the lowest cost plan will have negative consequences on network adequacy and market competition. Because the lowest cost plans often correspond with the narrowest networks on the Marketplace, we are concerned that consumers will opt into this re-enrollment option enticed by the premium implications, and end up with a plan that doesn't have a network of providers to adequately address their needs or with cost-sharing that substantially increases their out-of-pocket costs. Therefore, we would only support an "opt in" process at initial enrollment, as opposed to a process from which the consumer must opt out and the Exchange must provide sufficient education to clients regarding the process and the potential consequences to their access to care and drug coverage. Also, if lowest cost is the primary factor in determining which plan to automatically enroll consumers in, then consumers who opt into automatic enrollment should be assigned to at least the three lowest cost plans in the service area to increase competition.

   Additionally, we recommend that other factors be considered when determining a reenrollment hierarchy so that consumers can better maintain continuity of care, such as plans with similar provider networks and drug formularies. For example, machine readable data could be used to identify plans with the most similar provider networks and drug formularies to the consumer's current plan.

§155.410 – Annual Open Enrollment Period

We recommend that CMS create an open enrollment period for plan year 2018 and beyond that is more easily marketed and understood by consumers while retaining, to the extent possible, the current length of the open enrollment period. Therefore, we support shifting the annual open enrollment period to earlier in the year to start October 1 and to end December 15. The current structure for open enrollment periods makes it difficult to explain to consumers the "deadline" for enrollment. Under the current structure consumers must understand three deadlines, one for enrollment for coverage effective January 1, one for enrollment for coverage effective February 1, and then finally the actually final deadline. A recent study by the Kaiser Family Foundation found that only 7 percent of the uninsured could correctly identify the final deadline to enroll in coverage[1]. Therefore, we support an open enrollment that simplifies messaging to consumers by

[1] *Kaiser Family Foundation* Kaiser Health Tracking Poll. 2015 December 1-7. Available at http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-december-2015/.

effectively creating one deadline for consumers to enroll or re-enroll in coverage during the open enrollment period. Furthermore, an open enrollment period of October 1 through December 15 would provide some overlap with the annual open enrollment period for Medicare and many employer-sponsored insurance plans.

As discussed in the previous comment on the additional requirements of Navigator programs, CMS should provide sufficient time between the announcement of FFE Navigator funding and the beginning of the next open enrollment period for Navigator grantees to hire, train, and certify staff. For that reason, any change in the timing of the open enrollment period should include considerations to the Navigator funding announcement schedule (for years where this is applicable). Therefore, with our recommendation for an open enrollment to begin October 1 we also recommend a similar shift in the schedule for Navigator funding announcement. This is especially important given the additional requirements and training for Navigators included in the proposed rules.

§ 155.605 - Exemptions

We strongly supports CMS' proposal to eliminate unnecessary paperwork for individuals seeking an exemption from the individual coverage requirement due to their state's decision not to expand Medicaid. Specifically, we support CMS's proposal to remove the requirement that individuals who are ineligible for Medicaid due to their state's not implementing the ACA expansion must apply to Medicaid and receive a rejection prior to seeking an exemption, and the proposal to make this exemption available on an individual's tax return without the need for an exemption certificate number (ECN).

Medicare Notices

We encourage CMS to develop a comprehensive system to notify individuals in the Marketplace about nearing Medicare eligibility. Ideally, this system would include multiple types of notification and educational content that is appropriately timed ahead of an individual's Initial Enrollment Period (IEP) for Medicare. While we agree that online "pop-ups" can be a useful tool, we do not believe "pop-ups" will be sufficient to provide advance notice to individuals about nearing Medicare eligibility given the complexity of the Medicare enrollment process, particularly for those transitioning from the Marketplace to Medicare. Therefore, we strongly encourage CMS to develop mail and electronic notices for QHP enrollees becoming Medicare eligible due to age or disability.

Thank you for this opportunity to comment,

Center for Public Policy Priorities
Light and Salt Association
Texas Association of Community Health Centers
CentroMed Medical Clinics