



**American Hospital
Association**

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April 21, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, DC 20201

Re: CMS-9949-AS02, Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule, March 21, 2014 (Federal Register Vol. 79, No. 55, pgs. 15808-15879)

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule addressing various health insurance exchange and insurance market standards for 2015 and beyond under the Affordable Care Act (ACA).

Of the many proposed changes, our primary concern is with the proposed new requirements for consumer assistance entities (navigators, non-navigator assisters and certified application counselors (CACs)) and the establishment of civil money penalties (CMPs) for any breach of federal rules by any party, including consumer assistance entities such as a hospital. The establishment of CMPs is an extreme response when applied to all applicable federal rules, especially when other compliance enforcement mechanisms already exist. **The AHA believes applying CMPs to individual and institutional assisters, especially voluntary CACs, would have a chilling effect on some hospitals continuing to serve in that role.** Hospitals and other community organizations across the U.S. became CAC entities and voluntarily took on the responsibility for training staff and volunteers to become CACs. Their assistance with enrollment through the new exchanges, especially in those states with a federally-facilitated marketplace, contributed significantly to the level of enrollment that was achieved. **The AHA urges CMS to reconsider application of CMPs to voluntary assisters, and limit CMPs in general to egregious violations of selected requirements in which there are no other enforcement mechanisms already in place.**

Our detailed comments on this issue and others raised in the proposed rule are below.



SPECIFIC COMMENTS

CMPs for Violations of Applicable Exchange Standards by Consumer Assistance Entities (Sec. 155.206) and (Sec. 155.285). CMS states in Sec. 155.206 of the proposed rule that it would authorize CMPs to be imposed on consumer assistance entities who fail to comply with applicable federal standards. The agency in Sec. 155.285 of the rule proposes the bases and process for imposing such penalties. The enforcement process also would include requiring corrective action plans as an intermediate step that could be taken at the discretion of CMS. **The AHA recommends that CMS reconsider, clarify and scale back its enforcement approach to CMPs so that they address only the most significant violations that do not already have enforcement remedies in place.** Some of the more critical aspects of compliance relate to the protection of consumer personal information, inappropriate use of acquired information and unauthorized or prohibited disclosure of personal information, all of which are already governed by the Health Insurance Portability and Accountability Act.

The CMPs could be imposed for any noncompliance with federal rules, and CMS describes a variety of factors that would be considered in deciding whether to impose a CMP. Some of those factors “must” be considered – such as the compliance history of the entity, whether a consumer was harmed, and the frequency or gravity of the violation. Other factors “may” be considered – such as whether the violation was beyond the control of the consumer assistance entity, and whether the entity was paid to provide the service or did so as a volunteer. In some cases, the penalties imposed would be in addition to penalties that would already be authorized under other laws, and in some cases, other laws would take precedence to avoid duplicative penalties. It is difficult to determine whether duplication does or does not apply in many instances.

Viewed in a vacuum, these requirements could seem reasonable; however, in context, they are less so. The rules governing the exchanges, issuers and assisters are extremely complex, and they have been frequently changed, often in sub-regulatory issuances such as FAQs. This makes it extremely difficult for anyone, especially volunteer assisters, to identify and comply with the requirements.

There also are some provisions that are ambiguous, especially when viewed in the context of other provisions that are already in place. For example, under the conflict or interest rules, providers that perform CAC functions are required to disclose to potential applicants the health plans with which they have a contract to provide health care services. At the same time, they are prohibited from steering applicants or otherwise suggesting any preference be given to plans with which they have contracts. Those two things could be easily misconstrued. The important consideration is whether the assister objectively presents all of the options available to an individual. Another example is when CACs urge low-income individuals to enroll in Silver Level insurance plans because they are the only metal tier that enables financial assistance for cost-sharing

Ms. Marilyn Tavenner

April 21, 2014

Page 3 of 5

owed by a low-income individual. Would this be considered soliciting enrollment in a specific plan?

Another example of ambiguity relates to the new proposed prohibition on soliciting consumers for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact. We understand that some assisters have taken mobile vans with computers and in-person assisters to various communities to provide greater access to in-person assistance for consumers who would otherwise find it difficult to obtain in-person assistance. Often, the planned arrival of that mobile enrollment van is communicated to residents in the area through flyers and other means, some of which may involve door-to-door contact. Would this type of outreach be prohibited? If so, why would it be?

Yet another example is the new requirement for assisters to obtain a written authorization from each applicant prior to accessing that applicant's personal information. CMS has proposed that those signed authorization records be maintained and, in the case of federally-facilitated exchanges, kept for three years. If a provider used an electronic record and signature or scanned those authorization forms into a digital format, would that be considered a violation?

We raise these questions to illustrate that it could be very easy to make mistakes that do not stem from any inappropriate motivations on the part of assisters. And if the mistakes are imbedded in a processing system, the mistake would be made for all applicants. That would leave assisters open to substantial penalties that are simply inappropriate. **CMS must be clear about the type of violations that rise to the level at which a CMP is warranted, and it needs to avoid penalizing simple human errors of judgment or facts that are unintentional, non-malicious and consistent with the purpose of the ACA – to provide coverage to the uninsured.** An example would be providing an outdated list of plans with whom the provider contracts (lists for some institutions have more than 100 plans), but still presenting all of the plans available to the applicant.

Standards Related to Transitional Reinsurance Program (Part 153). CMS has proposed an annual prioritization process in the event that reinsurance contributions fall short of or exceed their estimates. That prioritization would go first to the reinsurance pool to pay claims and cover administrative costs up to the required statutory levels (\$10.2 billion in 2014, \$6.025 billion for 2015, and \$4+ billion in 2016). If contributions exceed those amounts, CMS would allocate any additional contributions to the U.S. Department of the Treasury, up to the statutory target of \$2 billion in 2014 and 2015 and \$1 billion in 2016. If contributions exceed that allocation as well, the remaining funds would be rolled over to the next year's pool of funds. **The AHA supports the adoption of such a prioritization, but recommends that, if possible, funds be allocated first to claims and administrative costs as proposed, but then rolled over to the next year's reinsurance pool, postponing payment to the Treasury until the end of the three-year program.** We believe that this slightly different approach would best stabilize the market and put the purpose of the reinsurance program first. We are particularly

concerned that temporary delays in the effective date of certain ACA provisions would shift some of the need for reinsurance protection from the first to the second and third years.

Revisions to the Temporary Risk Corridor Program (Sec. 153.500). To compensate health plans' additional administrative costs caused by several extensions of the enrollment deadline, CMS has proposed that the risk corridor program be modified in two ways for 2015. The first would be to increase the ceiling on allowable administrative costs by 2 percentage points (from 20 to 22 percent), and the second would be to increase the profit margin floor by 2 percentage points (from 3 percent to 5 percent). CMS also has proposed that the medical loss ratio (MLR) formula not take into account any additional risk corridor payments resulting from this adjustment. **The AHA agrees that plans should not be penalized as a result of increased administrative costs related to the program's rollout, but we recommend that risk corridor changes be limited to administrative costs at whatever level is deemed appropriate to the actual increased costs experienced.** Increasing the profit margin floor without regard to an issuer's increased administrative cost does not seem appropriate.

Non-discrimination Standards (Sec. 155.120). CMS requires all exchanges and assisters to comply with non-discrimination statutes and not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation. Only one exception to full compliance is included in the proposal – organizations that receive federal funds to provide services to a defined population when that organization also participates in the voluntary CAC program. **The AHA recommends that CMS reiterate the limited exception it provided last year for CACs to refer applicants who required special assistance that the CAC would have to pay someone else to provide.** When the CAC requirements were established last summer, AHA sought and received a clarification from CMS that when a CAC encountered an individual applicant that required a form of accommodation that was not readily available from that CAC (such as an infrequently encountered language or complex disability issue), it was permissible to refer that individual to the established navigator for the area or to the federal 800 number for assistance – two sources of assistance that are being paid under contract by the agency to provide assistance. We were concerned that any requirement that a volunteer CAC spend its own funds to purchase specialized assistance would discourage some facilities from participating in the program.

Quality Rating System for Quality Health Plans (QHPs) (Sec. 155.1400 and Sec. 156.1120). These sections of the proposed rule establish the requirement that exchanges prominently display on their websites quality rating information for each QHP offered. CMS proposes that the quality rating system be phased in beginning in 2015, with QHPs reporting data reflecting their first year on the exchange. This "beta test" and the data from the first year would not be publicly available in 2015. In 2016, data would be publicly available for performance in 2015. **The AHA believes this is a sensible approach to a new quality rating and reporting program.** However, we have mixed reactions to the proposed reporting by issuer and product type (e.g., preferred provider

Ms. Marilyn Tavenner

April 21, 2014

Page 5 of 5

organizations (PPOs), health maintenance organizations (HMOs)). Allowing the aggregation of data for all of an issuer's PPOs or HMOs could obscure important differences among an issuer's QHPs – not all PPOs or HMOs are created equal. At the same time, we understand the need to report at a level that has sufficient numbers to yield valid data. **The AHA recommends that CMS move to individual QHP-specific data as quickly as possible so that consumers have better information with which to select among plans.**

Thank you for the opportunity to comment on this proposed rule. If you have any questions about our comments, please contact me or Jeffrey Goldman, vice president of coverage policy at (202) 626-3649 or jgoldman@aha.org or Ellen Pryga, director of policy, at (202) 626-2267 or epryga@aha.org.

Sincerely,

/s/

Linda E. Fishman

Senior Vice President, Public Policy Analysis and Development