January 17, 2016

Andy Slavitt
Acting Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Submitted via email: FFEcomments@cms.hhs.gov

Re: Comment on the *Draft 2017 Letter to Issuers on the Federally Facilitated Marketplace*

Dear Mr. Slavitt:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefit specialists nationally. We are pleased to have the opportunity to provide comments in response the *Draft 2017 Letter to Issuers on the Federally Facilitated Marketplace.*

The members of NAHU work on a daily basis to help millions of individuals and employers purchase, administer and utilize health insurance coverage. Over the past few months, they have helped millions of their clients purchase marketplace-based coverage and will continue to support those clients throughout the 2016 plan year. As such, we have a critical interest in the continued development of the federally facilitated marketplace (FFM) and feel that the decisions being made now that will impact its structure and functionality in the year ahead will be critical to its future success. We have grouped our comments on the proposed letter by topic, as requested, and appreciate your consideration of our point of view.

Certification Process for Qualified Health Plans (QHPs)

With regard to the timeframe proposed in this document, NAHU encourages CMS to be mindful of the impact the certification process timetable can have on the entire marketplace. We appreciate that this year the proposed timetable for QHP certification appears to be complete by October 4, 2016, as this should, in theory, allow issuers the opportunity to release finalized QHP rates and plan designs to licensed and certified agents and brokers well in advance of the beginning of open enrollment. NAHU would further appreciate if the release of the plan designs and rates to certified agent and brokers and other applicable assisters be included in the official timetable, and that the timetable would allow for at least two weeks of review prior to the start of the 2017 open-enrollment season. For the last three open-enrollment periods, agents and brokers learned the final pricing of the products they were supposed to market on the same day that the individual market opened to consumers. Without adequate time to prepare and develop solid coverage recommendations for their clients, agents and brokers are forced to spend valuable open-enrollment time learning about the costs and features of various plans and doing client-specific analysis. That time would be far better used directly reaching consumers and working through options with them. NAHU believes that giving the individuals who help consumers directly as much time as possible to familiarize themselves with plan choices and prices would be very beneficial to the marketplace and consumers. We would

appreciate a CMS-required disclosure of plan information and rates to certified agents, brokers, navigators and other certified assisters by October 17, 2016, so that when the individual market opens for the year, they are fully prepared.

NAHU also encourages CMS to be aware of the impact the proposed certification timeframe may have on the product-development process at the issuer level. It is our understanding that the preparation and pricing of products to ready them for rate filings and the QHP certification process takes, on average, five months at the issuer level that must occur prior to the start of the QHP certification process. The current timetable appears to be respectful of this need at the issuer level and, when finalizing the timetable, we hope it will continue to be the case. If issuers have any less time to develop products and meet exchange deadlines, then we are concerned that they may limit product choices or refrain from offering products in certain service areas, which will hurt all insurance consumers and the FFM.

QHP and Stand-Alone Dental Plans (SADP) Certification Standards

Network Adequacy

Health insurance agents and brokers nationwide are acutely aware of the need for health insurance consumers to have adequate information at the time of purchase about health plan networks and formularies. Such information is critical if consumers are to pick the health plan that best meets their needs and budget. However, our members also know how important choice of health plan options is in the marketplace.

NAHU understands why CMS proposes to expand its network adequacy review processes for the 2017 plan year; however, we question the timeframe of the proposed expanded approach. As we mentioned in our formal comments on the proposed 2017 Notice of Benefit and Payment Parameters rule, it is NAHU's view that HHS should postpone any additional actions on network adequacy standards at this time beyond what was already in place in 2016 for the approval of qualified health plans. The National Association of Insurance Commissioners (NAIC) just spent many months working with relevant stakeholders and representative regulators from all states to develop a new model law on network adequacy. By proposing these measures before states have any opportunity to address the NAIC's work in their upcoming legislative sessions, we are concerned that HHS is undermining the NAIC's collaborative process. Furthermore, we are concerned that the overall approach outlined in the proposed rule and the specifics detailed in this draft letter to issuers completely ignore some of the significant discussion, feedback and decisions that state regulators made over the course of their months of work developing the model law. We also have concerns about how some of the proposed limits on tiered networks could limit the development of cost-saving and quality-enhancing health insurance products that utilize value-based design principles, including tiered networks. If HHS would delay its expanded network adequacy standards for a year, this would give state legislators and regulators time to consider the NAIC's work and enact measures that best fit the needs of their specific jurisdictions during their 2016 legislative sessions. Next year HHS could review the work done at the state level and determine if there are any gaps that may need to be addressed on a national marketplace level.

In this letter, we have specific concerns about the time/distance standards proposed as the federal fallback metric and note that the NAIC specifically declined to include such standards in its model after extensive discussion and agreement by regulators and stakeholders. In particular we have concerned with the 10 minute/5 mile standard

proposed for large metropolitan areas for primary care providers and note its inconsistency with the standard required for access to pediatric care of 30 minutes/15 miles. If CMS persists in using such metrics, we would suggest that both be adjusted to 20 minutes/10 miles.

We also take issue with the notification standard proposed for issuers to notify consumers in writing 30 days in advance for every network change with regard to providers they see regularly or from whom they receive primary care, regardless of the reason for the change. The letter proposes that issuers use claims data to determine who sees a provider "regularly" without providing true clarity to this standard. NAHU questions how effective this standard notification process will be, given that it is impossible to determine which providers a consumer may deem to be important to them with regard to network adequacy and coverage. A consumer could easily see a specialist regularly for a recent period for a specific treatment and not be concerned that the particular provider later left their network because their care needs in that area had been met. However, many consumers have specialists or other providers that they value but see quite infrequently. The use of claims data to determine "regular" customers of a provider will not only be imprecise and expensive for an issuer to do, but NAHU also questions the consumer appreciation and value of this proposed approach.

With regard to the continuity of care provisions for up to 90 days, NAHU appreciates the clarity as to what conditions may constitute "active treatment," although we would propose that it be limited to the third trimester of pregnancy for coverage, since the duration of the last trimester of pregnancy is much closer to the proposed 90-day timeframe. Furthermore, NAHU continues to have concerns about the length of the proposed timeframe generally due to cost and logistical concerns. If the continuity of care proposal is finalized, we recommend no longer than a 30-day coverage timeframe.

Instead of making significant changes to your network and formulary adequacy review for QHPs for 2016, we propose that CMS focus efforts for the 2017 marketplace on network and formulary transparency for consumers. NAHU supports the proposed transparency approach outlined in this letter concerning providing more direct consumer information in the marketplace online display with regard to both hospitals and primary care providers. NAHU members who work with consumers on enrollment every day report that this is by far the most important information needed by consumers to help them make informed choices, particularly for those who may be very price-sensitive with regard to purchases. While NAHU does not have specific concerns about the proposed methodology, it may be overly complex. We note that a very simple and consumer-friendly approach might be a display indicating how many and which hospital systems are covered by a plan by ZIP code and a listing of how many primary care providers for both children and adults are covered by ZIP code. In addition, further embracing the health insurance agent and broker community during open enrollment 2017 would address many consumer network and formulary concerns, as agents and brokers routinely assess how well each aspect of each plan choice will serve their clients' specific needs in these respects as part of their client advisory role.

NAHU also supports the provisions in the draft letter with regard to cost sharing for out-of-network services for essential health benefits provided in an in-network facility but by an out-of-network provider. NAHU members report that consumers in all areas of the country are being charged out-of-network cost sharing in these circumstances with high incidence rates, and it never fails to cause consumer frustration and dissatisfaction even when ultimately resolved. We believe that CMS's proposed solution to this issue is reasonable.

Discriminatory Benefit Design

NAHU requests clarification about the statement on page 45 of the draft letter that states, "We remind issuers that individuals under age 65 with end stage renal disease (ESRD) are not required to sign up for or enroll in Medicare." This statement seems to be inconsistent with another CMS publication "Who Pays First" with regard to Medicare secondary payer rules. One page 16 of that publication CMS notes, "If you're eligible for Medicare because of ESRD, your group health plan will pay first on your hospital and medical bills for 30 months, whether or not you have Medicare. During this time, Medicare pays second. The group health plan pays first during this period no matter how many employees work for your employer, or whether you or a family member are currently employed. At the end of the 30 months, Medicare pays first. This rule applies to most people with ESRD, whether you have your own group health plan coverage, or you're covered as a family member." The verbiage in this brochure would seem to indicate that individuals with ESRD in this coverage situation, you are ultimately required to sign up for Medicare or are auto-enrolled, as Medicare becomes your secondary payer. To assist brokers helping consumers in these situations and provide them with the correct information, we hope that CMS will provide more nuanced information about ESRD individuals and their Medicare rights and responsibilities in the final version of this letter.

Other Certification Issues

NAHU requests that CMS stipulate in the final version of this letter that, for plan year 2017 and all out-years, if an issuer files a premium rate with the state that includes broker compensation and the filed premium rate and plan design is ultimately approved by the CMS QHP rate review and certification process, then as a condition of approval the issuer may not alter the general compensation rate for brokers proposed and approved for the duration of that plan year. Such a requirement should not preclude an issuer from suspending broker compensation in the case of individual broker proved misconduct, but should prevent an issuer from altering a commission structure included in filed and approved rates for all brokers or a set grouping of brokers (such as appointed brokers) in the midst of the plan year.

Currently, issuers in multiple states are in the process of implementing mid-year commission changes for the individual market that would impact the special enrollment period (SEP) for 2016 even though rates filed for these products include commissions and the premiums for such policies are not being correspondingly reduced. NAHU is very concerned about the impact this practice will have on consumers and believes that it is within CMS's authority to address it with issuers on several fronts. While CMS has been very clear that it does not require or regulate broker compensation for marketplace products, CMS does stipulate that if an issuer provides broker compensation, then the issuer must provide the same level of compensation for all substantially similar QHP products, regardless if they are sold via the exchange marketplace or in the off-exchange marketplace. The reasoning for this requirement is CMS's direct authority to both enforce the ACA's guaranteed-issue requirement and to ensure stability in the exchange marketplace. If the compensation environment is not kept level for substantially similar products both on- or off-exchange, then the guaranteed-issue provisions of the law are undermined as individuals might not have access to all products through their brokers and people may be unknowingly directed to one market or another, creating an unlevel market playing field and consumer harm. The same threats to the ACA's guaranteed-issue requirements and market stability protections apply to a mid-year commission policy change by an issuer. If an issuer provides brokers with one commission rate during open enrollment then reduces rates for the remainder of the plan year during the special enrollment period, an individual's access to coverage and exposure to all channels of consumer assistance will be diminished. This is especially true of a commission change

that impacts the SEP, since consumers with SEP rights often need the most help taking advantage of their special status. Furthermore, by reducing their rate to a noncompetitive level midway through the plan year, an issuer may be able to inappropriately shift risk to other issuers in the marketplace causing instability for all. If an issuer reduces its commission rate to zero after the open enrollment process ends, then the issuer can unfairly shift almost all of its potential SEP risk, and certainly all broker-driven risk, to other issuers. If a broker is not being paid for his or her services, then no client relationship is established with the consumer and the broker's errors and omissions insurance coverage (which protects both the consumer and the broker) does not apply to the relationship and real or potential transaction, thereby making broker support and service on a newly non-commissioned policy impossible.

NAHU also believes that CMS has the responsibility and authority under its rate review and QHP certification processes to ensure that issuers maintain the services that they promise via filed and approved rates throughout the plan year. Much like CMS stipulates that issuers may not change and reduce their initially specified service areas mid-plan year, we believe it would be appropriate for you to stipulate that the services promised as part of approved rates, including access to the purchasing services and plan year, and renewal consumer support offered by a licensed health insurance agent or broker, not be eliminated partway through a given plan year. Otherwise, consumer services that are promised as part of the approved rates of the policy may be reduced, and the consumer would see no corresponding premium reduction.

FFM Oversight of Agent and Brokers

Broker Conduct Enforcement

In the proposed 2017 Notice of Benefit and Payment Parameters, CMS proposes immediate temporary suspension of a broker in the case of suspected fraud or abusive conduct for up to 90 days. The proposal notes that, during this suspension, brokers could provide documentation that a charge was made in error and that reinstatement could be made more quickly than 90 days. NAHU would like detailed clarification about the proposed timeframe and requirements by HHS for broker due process and hopes that this clarification will be provided in the final issuer letter should this proposal (or any amended version of this proposal) be codified in the final rule. Ninety days is almost the length of the entire open-enrollment period, and if a broker was in fact innocent of wrongdoing, he or she could be shut out of helping consumers altogether for the season if the case was not resolved quickly. In addition, the broker has the option to appeal and provide documentation, but these processes for brokers, including when, how and to whom documentation should be submitted, is not specified. NAHU would like explicit timeframes and notification processes clarified in any final issuer letter.

NAHU has concerns about how CMS proposes to coordinate enforcement efforts with state regulators. While we recognize the responsibility of the FFM to investigate and take action against any cases of serious misconduct that impact the exchange marketplace, given that state regulators are the primary regulators of broker conduct across all market spheres, we believe that state officials should be involved and alerted to suspected misconduct immediately so that they too can take appropriate action if needed. We also note that states have long-established processes for handling potential broker misconduct. NAHU believes that rather than the exchanges initiating separate investigations and processes with regard to potential misconduct, consumers, the exchanges, states and agents and brokers will all best served if exchanges would simply work with state regulators within the existing enforcement framework at the state level.

Web Brokers
NAHU supports provisions for conspicuous notice to the consumer to ensure transparency and consumer protection. Concerning privacy, data security and compliance processes, we encourage CMS to minimally require the submission of each WBE and issuer's MARS-E Compliance Manual that details how they manage their compliance process, with particular attention to the implementation and maintenance of a MARS-E compliance level. WBEs and issuers who fail to materially meet MARS-E standards should not have access to the proposed streamlined application process until such time as they can demonstrate compliance.

Broker Compensation
In addition to our request that commissions outlined in filed and approved rates and QHP certification documentation be maintained throughout the plan year for consumer-protection and market-stability reasons, NAHU would like to express support for CMS's recognition that occasionally broker identifying information is left off 834 files. The omission can impact broker compensation for a given case and your stated expectation that individual issuers address this matter expediently with their contracted brokers is appreciated. In order to protect against this circumstance, in addition to issuers taking action, NAHU would like to request that CMS allow for multiple assister numbers to be including on the marketplace application. Not only is this an important consumer protection, as it would help keep an accurate record of all individuals who provide help to a given consumer with marketplace transactions, but it would also guard against an agent's number being inadvertently removed and replaced by another assister midway through the application process (such as a call center operator helping both the consumer and the agent resolve a problem), thereby affecting the broker's compensation.

Re-enrollment Transactions
With regard to the letter's content concerning reenrollment transactions, NAHU is concerned about the language used that states: "Because passive re-enrollments assume that agents and brokers are not providing assistance to consumers…"NAHU recognizes and appreciates the goal of CMS to ensure that the agent of record stays on a case in the situation of a passive re-enrollment and the policy of allowing an agent to continue to receive compensation if offered by the QHP in the case of a passive re-enrollment even if the agent no longer is certified to sell and service other FFM products. However, numerous NAHU members objected to the "assume…not providing assistance" phrasing since, in many cases, the passive enrollment is a conscious choice made by both the consumer and the agent after a complete review of the individual's situation indicates that staying in the current plan and a passive re-enrollment is the best choice for the client. In the final letter, we request that you consider different phrasing. An alternative might be "Since in a passive re-enrollment situation, there is no direct contact with the FFM, agents and brokers would not need to have a current registration…"

Broker Training
NAHU very much appreciated the opportunity to serve as an approved vendor offering training and information verification services to brokers wishing to serve consumers through the federally facilitated exchange marketplace during 2016. Based on this experience, we support the proposed change that would eliminate the requirement that vendors conduct identity-proofing as the current year's experience indicated that it was not needed and was duplicative of existing marketplace practices.

NAHU also requests that vendors be able to provide tier-two support to brokers who are having trouble navigating the CMS Enterprise Portal and hopes that the final letter to issuers will address this issue. The majority of help-

desk inquires NAHU received as a training vendor revolved around verification of completion codes/errors and/or general account navigation in the CMS Enterprise Portal. It would be helpful if vendors had access to agent/broker CMS accounts to view issues, correct errors and provide support, rather than having to advise agents and brokers verbally about account issues without visualization. NAHU also suggests the development of scripted response(s) using vendor input be provided to vendors at least two weeks prior to the FFM training launch.

Standards of Conduct

Finally, NAHU has concerns about the proposed standards of conduct that would extend to businesses and agents that use the words "exchange" and "marketplace" in their names and websites. NAHU does not in any way support websites operated by brokers or any others that are intentionally misleading to consumers and attempt to confuse them relative to the federal marketplace. In addition, we support the required disclaimer to note that the entity or website is not the federal exchange and requirement to include a link to HealthCare.gov. However, we also note that the words "exchange" and "marketplace" are common and have been part of the names (and also web addresses) of many long-standing insurance-related businesses established well before the federal marketplace was envisioned. For example, a NAHU-member company, The Insurance Exchange, has been operating as one of the largest general insurance agencies in Texas for decades. Businesses like this should be able to continue to operate and market online as they have for years without fear of federal reprisal. We request that the final issuer letter acknowledge that there are entities that have used these words in their name for years prior to the creation of the FFM, that these entities are in no way trying to confuse consumers by maintaining their longstanding corporate identities and that HHS does not expect for these businesses to change names, websites, trademarks, etc. that have long been part of their business identity.

FF-SHOP Marketplace

NAHU recognizes that the FF-SHOP will not have the ability to calculate premiums based on average enrollee premium amounts (composite rate) for the 2017 plan year. While we understand the logistical challenges with this practice, we caution that it may be an impediment to SHOP selection and enrollment for certain employer groups who value composite rating for human resource reasons.

With regard to the proposed changes to the FF-SHOP employer notices, the draft letter stipulates, "while the FF-SHOPs will be sending notices describing the renewal process to employer groups and employees, this does not relieve issuers of their renewal notice requirements." NAHU members working with FF-SHOP employers in the field report that employers sometimes get confused when they receive two separate renewal notices with two separate sets of renewal criteria from two entities (the FF-SHOP and the issuer) at different times. To make things simpler for business consumers, NAHU suggests that the FF-SHOP coordinate the timing of their renewal notices to ensure that the group has met the issuer's participation and certification requirements before they receive renewal information from the FF-SHOP. NAHU members in the field report cases of groups receiving renewal information from the FF-SHOP and assuming that they were eligible to reenroll, only to find out much later from the issuer that they were not in fact eligible and needed to find another coverage alternative.

The proposed letter also notes "qualified employees will not be able to make changes to the Social Security Number (SSN), date of birth (DOB), gender, and name for themselves or their dependents as part of the renewal process. These changes can be made by qualified employers by contacting the FF-SHOP Call Center. Issuers will receive

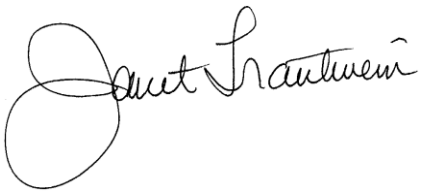
maintenance transactions for these changes. Changes to enrollee contact information can be made as part of the qualified employee's renewal process. These changes will be sent on renewal transactions." With regard to this process, NAHU requests that notification of completion also be provided to the employer.

Consumer Support

Agents and brokers very much appreciate the creation of dedicated call center representatives for them to report issues to during the 2016 open enrollment season. Brokers also need a means of tracking their clients' cases and ensuring follow-through and resolution. We recognize that the Health Insurance Casework System is intended for issuer and CMS use, but often brokers are the ones helping their clients through the consumer complaint process. We request that, for 2017, the FFM continue to develop a specific means for providing certified agents with more client support as well as a method for them to track problem cases and their resolution for their clients.

NAHU sincerely appreciates the opportunity to provide comments on this letter and we look forward to working with you in the year ahead. If you have any questions or need additional information, please do not hesitate to contact me at either (202) 595-0787 or jtrautwein@nahu.org.

Sincerely,



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