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Submitted by email to: www.regulations.gov

October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-9989-P

Re: Establishment of Exchanges and Qualified Health Plans
File Code: CMS-9989-P
Docket ID: HHS-OS-2011-0020

Ladies and Gentlemen:

These comments to the proposed rule on the Establishment of Exchanges and Qualified Health Plans¹ are submitted on behalf of the American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO") and its 56 affiliated unions. The AFL-CIO, together with its community affiliate, Working America, represents more than 12 million workers.

Unions negotiate health benefits for some 50 million workers, retirees and family members in the United States. These plans have developed in a variety of ways in order to meet the needs of workers and employers in specific sectors of the economy. They include designs, structures and administrative operations that differ substantially from those found in commercial

¹ The proposed rule, issued by the Department of Health and Human Services ("the Department" or "HHS"), is published at 76 Fed. Reg. 41866 (July 15, 2011).

health insurance plans, including different governing statutes such as ERISA, the Public Health Service Act, and state law. Multiemployer plans, for instance, are a very important vehicle for providing comprehensive health benefits and continuity of coverage as participants move from job to job or employer to employer. They are the result of the continuing commitment and deep involvement of their sponsoring unions, as well as their contributing employers. But they are also independent organizations, managed jointly by both labor and management trustees.

In setting the regulatory framework for the creation and operation of Exchanges, the Department needs to take care to avoid disruption of the very successful plans, such as multiemployer plans and union-based health trusts, which are already operating under the principles of affordability, consumer-focus, and patient-centeredness.

Implementing the Exchange provisions of the Affordable Care Act² and, at the same time, ensuring the continuation of employment-based health coverage, will require the Department to take into account the realities and complexities of existing health coverage, at the same time as being faithful to the letter and spirit of the new law, including the principle that people who like the coverage they now have will be able to keep it.

While it is impossible to predict how many individuals with either employer-sponsored coverage or multiemployer plan coverage will instead be required to purchase health care coverage through the Exchanges, substantial financial incentives exist for employers to drop coverage beginning in 2014. In that regard, a significant number of reports raise the possibility of large-scale loss of employer-sponsored insurance tied to the creation of Exchanges. “At least three different surveys conducted since June 2010 have found that if some employers drop coverage, a great many more will at least consider following suit.”³

In light of such widespread reports, coupled with the continued, intense pressure that rising health costs put on employers and plans, it only seems prudent to take every possible step to minimize the risk of the substantial loss of employment-based coverage.

The federal regulatory framework will send a critically important signal that will affect the thinking and planning of sponsors of benefits for private and public employees. To the extent that framework signals an intent to preserve employment-based coverage by providing flexibility for sponsors to participate in Exchanges in a variety of ways, it will help preserve existing coverage. To the extent that it provides no economically viable choices for the

² The terms “Affordable Care Act” or “Act” refer to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 collectively.

³ *Will Employers Drop Health Coverage in 2014? Or Just the Opposite?*, Purchasing High Performance (The Commonwealth Fund and the National Business Coalition on Health), September 19, 2011 available at <http://www.commonwealthfund.org/Newsletters/Purchasing-High-Performance/2011/September-19-2011/Perspectives-on-Policy/Will-Employers-Drop-Health-Coverage-in-2014.aspx>.

continuation of employment-based coverage in some fashion, it will encourage employers to withdraw such coverage.

For this reason, employers and workers would be best served by a path with many options along the way.

Existing plans, whether single-employer plans, multiemployer plans, union-based or joint union-employer health trusts, or state and local government plans, could well disappear if employers' only genuine choice was to move workers into Exchanges. For workers currently covered by effective health plans, their existing coverage could well be replaced by inferior, more costly coverage offered by the large commercial carriers that today dominate the insurance market.

The budget estimates done for the Act did not, we believe, include the costs of the significant additional federal subsidies that would be required should such wholesale employer withdrawal take place. Nor did the sponsors of the Act foresee such a massive transfer of financial liability from employers to the federal government. Clearly, it would be preferable to maintain as much continued employer support as possible for coverage, rather than shift the responsibility to individual workers, their families and the federal government.

As the Department interprets the Exchange-related provisions of the Act in developing regulations, a paramount objective should be maintaining employer-based coverage by making the Exchanges compatible with employment-based coverage and structuring a smooth interface between such coverage and that available through Exchanges.

To this end, we urge the Department to:

1. Make explicit in the implementing regulations that preserving employment-based coverage is a top priority.
2. Allow maximum flexibility for the sponsors of employment-based coverage to work with and through Exchanges.
3. Require strong, meaningful participation of unions and the sponsors of employment-based coverage in public advisory boards to Exchanges.

Allow Employers and Plans to Supplement QHP Coverage

An important step that the Department could take to reduce the risk of employers withdrawing from coverage or substantially reducing existing coverage would be to allow employment-based plans to use plan funds⁴ to supplement Exchange coverage by directly paying

⁴ We refer here to direct payments by employment-based health plans and not payments through individual accounts. Such accounts represent a move away from defined benefit plans and towards defined contribution plans that shift the burden of health costs onto workers and their families. Well-documented experience has shown that such a shift can rapidly lead to unaffordable care and the forgoing of necessary medical treatment.

employee cost-sharing and/or providing ancillary coverage, e.g., dental and vision. Otherwise, very large numbers of workers will likely move from plans with good benefits and affordable contributions to Exchange plans that are widely predicted to have prohibitively high contribution requirements.

The final rule should allow the coverage provided by QHPs offered through the Exchange to be supplemented by employer-sponsored plans, stand-alone retiree plans, and multiemployer plans. The regulations should make clear that these plans may supplement QHP coverage with dental, vision and other ancillary coverage, as well as offset premium and/or cost sharing burdens. Making this option available would permit employees and retirees to maintain at least the same level of coverage even if employers are no longer willing to provide the same benefits they had before the establishment of the Exchanges. In addition, allowing the coordination of coverage maintains the connection between unions, workers and retirees with respect to health care benefits as well as preserving a level of employer contribution for those benefits.

Treatment of Multiemployer Plans

For decades, multiemployer plans have provided affordable, high quality health care coverage for millions of workers and their families and played a pivotal role in providing benefits across the economy, particularly in industries with fluid employment patterns. Maintaining these plans, which today cover approximately 26 million workers, retirees and their families, must be a priority as the Department develops its guidance on Exchanges.

Multiemployer plans, established as non-profit plans under Section 501(c)(9) of the Internal Revenue Code (“Code”), are maintained through collective bargaining and sponsored by a joint board of trustees consisting of equal numbers of representatives appointed by participating unions and employers in accordance with Section 302(c)(5) of the Labor Management Relations Act of 1947, as amended (“LMRA”). The board of trustees, not the contributing employers, designs the benefits plan. Each participating employer makes contributions to the plan as required by the applicable collective bargaining agreement.

The unique structure of multiemployer plans allows these plans to provide affordable, high quality coverage to workers in industries with fluid employment patterns. Multiemployer plans cover workers across the economy, including those in the airline, automobile sales, service and distribution, building and construction, building, office and professional services, entertainment, food production, distribution and retail sales, retail, wholesale and department stores and trucking industries. These plans can provide health care coverage on a local, regional, multi-state, or national basis, and the coverage is typically designed to meet the needs of the particular industry.

Participants in multiemployer plans often move from one contributing employer to another. Because these plans allow participants to combine their work with all employers and

the related contributions, they become eligible for, and maintain, health care coverage on a continuous basis. In addition, plans also offer health care benefits to part-time workers, a group often excluded from employer-provided coverage.

Multiemployer plans also offer smaller employers the opportunity to pool resources with other employers and provide affordable, cost-effective health coverage to their workers. These smaller employers might not otherwise be able to obtain affordable health coverage due to their size or the mobility of their workers. It is estimated that approximately 90 percent of the employers who contribute to multiemployer plans are small employers and in some industries, like construction, most employers have 20 or fewer employees.

These plans are attractive to employers because they provide consistent long-term health coverage for workers with predictability and cost-effectiveness for employers. Multiemployer plans are also beneficial for employees because they provide, among other things, portability, consumer-oriented plan design and administration and stability.

Multiemployer plans provide member-focused coverage, including prevention and chronic disease management and education to make sure participants understand and effectively use their benefits. A key feature of multiemployer plans is their status as non-profit entities and consistent with the laws governing these plans,⁵ all of the assets of these plans may only be used to provide benefits and pay the reasonable costs of administration. In contrast to the large for-profit insurers that have mounted an intense campaign to roll back the medical loss ratio standards in the Act, multiemployer plans generally have very low administrative costs, typically less than 10 percent, and therefore devote a very high proportion of contributions to actual care.

Multiemployer plans provide significant coverage to part-time workers because participation is based on hours worked at all employers. One of the major shortcomings in the Act is the likelihood that a substantial loss of employment-based coverage will occur because of the incentive for employers to reduce the number of full-time jobs, thereby avoiding either providing coverage or paying the employer responsibility penalty. Multiemployer plans operate on the opposite principle, that as many workers as possible in the covered industries should get benefits, whether they work a small number of hours for various employers, or not.

The ability to provide comprehensive coverage at low cost correlates directly to the non-profit nature of multiemployer funds and their demonstrated ability to engage in highly cost-effective direct purchasing from providers. Multiemployer plans also are known to use innovative clinical programs, such as one in Atlantic City,⁶ that target high risk workers and

⁵ In addition to Section 302(c)(5) of the LMRA and Section 501(c)(9) of the Code, the Employee Retirement Income Security Act of 1974, as amended, regulates “welfare benefits plans” which include multiemployer plans providing health care benefits.

⁶ Atul Gawande, *The Hot Spotters*, The New Yorker, January 24, 2011 (available at http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande)

family members for intensive chronic disease management. Thus, multiemployer plans are positioned to play a leading role among private purchasers of health care in “bending the cost curve.”

The provisions of the Affordable Care Act do not address how multiemployer plans will continue their vital role in providing health care coverage once the Exchanges are established. The Department, as it finalizes the Exchange regulations, must consider how best to preserve multiemployer plans. We support the proposals made by the National Coordinating Committee for Multiemployer Plans to address the continuation of these plans.

Eligibility Standards for SHOP §155.710

The employer eligibility standards for the Small Business Health Options Program (“SHOP”) in the proposed rule are based on the definition of “qualified employer,” set forth in Section 155.20 of the proposed rule. Generally, qualified employers are small employers which until 2016 can be limited by the states to employers with 50 or fewer employees. Beginning in 2017, qualified employers will include large employers if the state allows these employers to purchase coverage through the SHOP.

Because access to the SHOP is limited to employers, the proposed rule, as well as the provisions of the Act on which it is based, fails to take into account other entities that provide health care coverage to employees and retirees. These entities include multiemployer plans and plans funded by stand-alone voluntary employees’ beneficiary associations that cover retirees. Allowing multiemployer plans to purchase coverage through the SHOP could mitigate the incentive for contributing employers to end their participation. For stand-alone retiree plans, access to the SHOP may allow these plans to continue to provide benefits if coverage through the SHOP proves to be more cost-effective and affordable.

Multiemployer plans combine the purchasing power of many employers to leverage cost-efficient, consumer-oriented coverage for employees and retirees. These plans should be allowed to continue playing this role as Exchanges develop by being able to purchase coverage through the SHOP on behalf of contributing small employers who would otherwise be eligible to purchase that coverage. Further, because approximately 90 percent of contributing employers are small employers, multiemployer plans should be allowed to perform this intermediary function even if some percentage of their contributing employers is large employers.

QHP Issuer Participation Standards §156.200

Unions have a long history of offering benefits to their members (including associate members), and they should be able to do so through a QHP offered in an Exchange. For example, under the Federal Employees Health Benefits Act, 5 USC §§ 8901-8914 (“FEHBA”), employee organizations, including unions, are allowed to sponsor plans on the FEHBA exchange. These plans are allowed to limit enrollment to members of the employee organization

(including associate members) so long as membership is not be restricted based on age, race, sex, health status or the hazardous nature of employment. 5 CFR §890.201. With several decades of experience, it is clear that these union-sponsored plans have succeeded in providing the kind of consumer-oriented care for their members that is fundamental to the Act's purposes.

Neither the Act nor the proposed rules would expressly restrict unions or other membership organizations from partnering with a QHP issuer to offer a qualified health plan ("QHP") limited to members of the partnering organizations. The proposed rule in paragraph 156.200(e) prohibits discrimination based on race, color, national origin, disability, age, sex, gender identity or sexual orientations. Section 1312(a)(2) of the Act suggests that QHP eligibility provisions that do not otherwise violate the Act are permitted. That section provides that "[a] qualified individual may enroll in any qualified health plan available to such individual and *for which such individual is eligible*" (emphasis added).

We suggest language be added to the final rule making clear that such a membership-only QHP would be permitted so long as the following two conditions are satisfied. First, membership eligibility criteria for the organization could not include any health status-related or other prohibited factors, and second, the QHP available only to members would be the same as one of the required plans or another QHP offered by the issuer in the Exchange.

Our suggested membership limitation is consistent with the guaranteed issue requirement under Section 2702 of the Public Health Service Act. Under that section, a health insurance issuer offering coverage in the individual market must accept anyone that applies for coverage and a similar requirement applies with respect to employers for coverage in the group market. Under our proposal, the QHP issuer would make identical coverage available to all individuals that satisfy the guaranteed issue requirement, and the offer of a plan limited to members provides an additional option.

Entities Eligible to Carry Out Exchange Functions **§155.110(a) Eligible Contracting Entities and §155.110(b) Responsibility**

We support the requirement that, in the event an Exchange enters into an agreement with an eligible entity to carry out one or more of its functions, the Exchange remains the principal entity responsible for ensuring that all federal requirements are met. However, certain Exchange functions are inherently governmental and must be performed by public entities.

While we recognize the possible benefit or need for an Exchange to seek agreements with eligible entities, particularly the state Medicaid agency, we are concerned that certain functions may not be appropriate or eligible for outsourcing to a third party, non-governmental entity as they are inherently governmental functions. Specifically, the process of making determinations of an individual's eligibility for Medicaid, the Children's Health Insurance Program ("CHIP"), or federally funded premium assistance credits or cost-sharing reductions should not be contracted out to private entities nor should the appeals process for eligibility determinations.

Section 1313(a)(5) of the Act directs that “the Secretary will provide for the efficient and nondiscriminatory administration of Exchange activities...” This provides a clear basis, and signals strong intent, for the Secretary to ensure that states use governmental staff to perform critical Exchange functions and prohibit states from privatizing inherently governmental functions.

Moreover, many functions of the Exchange are “inherently governmental,” as defined in OMB Circular No. A-76 (revised 2003).⁷ One of the purposes is “to make agencies accountable to taxpayers for results achieved....” The Guidance states that:

“An inherently governmental activity is an activity that is so intimately related to the public interest as to mandate performance by government personnel. These activities require the exercise of substantial discretion in applying government authority and/or in making decisions for the government. Inherently governmental activities normally fall into two categories: the exercise of sovereign government authority or the establishment of procedures and processes related to the oversight of monetary transactions or entitlements.”

Applying these principles to the Exchanges, HHS should determine the following activities to be “inherently governmental” and not eligible for contracting to a non-governmental entity:

- Establishing standards for qualified health plans offered in the Exchange;
- Negotiating with or selecting plans to participate in the Exchange;
- Certifying and decertifying plans to be offered in the Exchange, including the ability to exclude plans if it is in the interests of individuals and employers in the state;
- Regulating the practices of insurance plans in the Exchange including monitoring marketing practices, ensuring that benefits are not designed to cherry pick healthier enrollees, ensuring adequate choice of providers, and monitoring the handling of consumer complaints;
- Administering risk adjustment mechanisms among participating insurers;
- Determining whether individuals qualify for the federal premium assistance credit and the cost-sharing reductions and if they do not, screening them for eligibility for public programs like Medicaid and the Children’s Health Insurance Program;
- Establishing and administering an appeals process for individuals denied eligibility for premium assistance credits;
- Determining hardship exemptions from the individual responsibility requirement;
- Determining penalties for employers who do not provide health care benefits or provide benefits that are not affordable or adequate if any full-time employee obtains premium assistance credits and administering an appeals process for employers challenging penalties;

⁷ Revision to the Office of Management and Budget Circular No. A-76, “Performance of Commercial Activities.” 68 Fed. Reg. 32134 (May 29, 2003).

- Establishing policies and procedures for verification of Social Security numbers, tax credit eligibility and immigration status with federal agencies;
- Resolving inconsistencies with information as reported by the Social Security Administration, Department of the Treasury or Department of Homeland Security;
- Handling and transmitting a variety of confidential information, including federal income tax return data, income and other information included in Medicaid applications, and Social Security Administration data;
- Establishing eligibility criteria, selecting and overseeing the Navigator program; and
- Assessing fees to participating health insurers or to otherwise fund the ongoing operation of the Exchange.

Because decisions made by the Exchanges will determine, for example, whether individuals and families qualify for the premium tax credits and thus obtain health coverage, strong public accountability for the performance of these functions is essential. Whether they are performed well or poorly would not only affect these individuals and families, but also taxpayers who will be responsible if costs are higher than they otherwise would be. We believe the best way to ensure accountability is through the use of governmental staff to carry out these functions without bias and conflicts of interest and in the best interest of the public.

We recommend that OMB Circular No. A-76 (revised 2003) be referenced in the final rule as model guidance to the states on what functions should be performed by governmental staff and what may be contracted out under the supervision of a governmental entity.

Although many functions of the Exchanges should be performed by governmental staff, it may be appropriate to delegate some functions to private contractors. In particular, mechanical functions such as data processing and other IT requirements, as well as billing, collection and payment reconciliation of premiums could be considered for private sector contracting where competitive markets exist and for which performance can be readily monitored.

The final rule should include provisions requiring contracting entities to meet conflict of interest and confidentiality standards to ensure that the Exchange, HHS and the public know of any vendor's potential financial conflicts and to protect the personal data of consumers.

In addition, Exchanges should be required to obtain approval from HHS for contracts in excess of \$5 million (\$1 million in the case of noncompetitive acquisitions), similar to the approval requirements for Supplemental Nutrition Assistance Program Automated Data Processing contracts. Including this requirement, instead of merely sharing copies of final agreements, may avoid expensive contract that produce poor results. For smaller contracts, HHS should encourage states to share potential contract language in advance as part of its ongoing communication process.

Entities Eligible to Carry Out Exchange Functions

§155.110(c) Governing Board Structure and §155.110(d) Governance Principles

It is critical for the Department establish minimum requirements for all Exchange governing boards. In particular, we support the requirement that any governing bodies must be administered under a publicly adopted charter or bylaws and must hold regular public meetings with advance notice to the public. Additional requirements to ensure transparency, openness, and fair practices should be included.

We strongly recommend that HHS require that all Exchange governing boards prohibit membership of individuals with clear conflicts of interest. It is detrimental to the goal of the Exchange and to taxpayers supporting premium assistance credits if Exchange boards are comprised of parties with a financial interest in increasing the cost of health insurance. Individuals with clear conflicts of interest should be explicitly defined in regulations as those affiliated with health insurance issuers, insurance agents or brokers, health care providers or health care facilities. In addition, the prohibition should explicitly extend to individuals affiliated with an entity whose primary line of business serves, or whose clientele is largely comprised of, individuals or organizations identified as conflicted parties, such as major vendors, subcontractors, or other financial partners.

We recommend that HHS clearly define representatives of consumer interests. Such a definition should include: individuals who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the individual exchange; small business employers who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the SHOP; and non-profit organizations and unions that represent or advocate on behalf of the individuals in the categories mentioned. Additionally, for purposes of board membership, HHS should separately define representatives of small employers as small business owners who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the SHOP. HHS should perhaps include language in the regulations that permit this definition to be adjusted once a state permits larger employers to enter the SHOP.

If HHS intends, as stated in the preamble and section 155.110(c)(3), to ensure that Exchange governing boards predominantly represent consumer interests, then the final rule must be more explicit. Specifically, if HHS ultimately will permit conflicted parties to serve on these boards, there should be more representatives of consumer interests (as defined above) than conflicted voting members, and consumer interests should constitute an overall majority and a voting majority of the board. A precedent for such a requirement exists in 42 USC § 254b(k)(3)(H) regarding the requirements of governing boards for Federally Qualified Health Centers (FQHCs), where a majority of the board must be individuals being served by the health center.

We also strongly recommend that HHS be more explicit in the standards Exchanges must meet in terms of their policies on ethical practices and conflict of interest. Specifically, HHS should set a minimum standard requiring board members and staff to:

- Disclose any affiliations (financial or otherwise) that may cause the appearance or presence of a conflict of interest with their role in an Exchange;
- Recuse themselves from all discussion and votes associated with such conflict;
- Refrain from accepting any gifts (or any gifts exceeding a reasonable limit) from any individual or entity that can be considered a conflicted party; and
- Report any potential unethical action or transgression on behalf of themselves, staff, board members, or vendors.

Stakeholder Consultation §155.130

Section 1311(d)(6) of the Affordable Care Act requires Exchanges to consult with a range of stakeholders in carrying out their responsibilities. The statute lists five stakeholder groups and the proposed rule expands that list by adding six more groups, including large employers.

Unions should be included among the stakeholder groups that Exchanges must regularly consult. Over many decades, unions have negotiated with employers for the provision of health care benefits, offered health care benefits to their members and acted as advocates of working families on health care issues. Through their varied roles, unions have a substantial interest in, and wealth of knowledge about, the design and operation of Exchanges, and they should be part of the consultation process.

Including unions among the stakeholder groups to be consulted is consistent with the Department's rationale for expanding the statutory list as doing so will provide additional input and viewpoints from a significant group impacted by the Exchanges.

Navigator Program Standards §155.210

The Navigator program will be a key part of Exchange education, outreach and enrollment efforts, and the rule should ensure that the entities acting as Navigators will serve potential Exchange enrollees without conflicts of interest and with appropriate training and certification.

In paragraph 155.210(b)(1)(iii), the proposed rule allows the state or the Exchange to set the licensing, certification or other standards that Navigators must satisfy. Navigators should be appropriately trained to ensure they are knowledgeable and understand the health coverage issues on which they will provide assistance, and they should comply with strong ethical standards. However, allowing each state or Exchange to determine the licensing, certification or other standards is likely to result in varying requirements, and in our view, it would be more

appropriate for the Department to establish uniform, national rules in order to offer consistency and certainty.

One of the concerns with permitting states or Exchanges to set the licensing and certification standards for Navigators is the possibility of requiring inappropriate licensure, such as producer licenses for all Navigators. Requiring all Navigators to have a producer license is contrary to the intent of the program to provide assistance to potentially eligible individuals through a range of entities with connections to different segments of the population. In addition, requiring a license could also interfere with the ability of entities, including unions, to participate in the Navigator program. The final rule should provide that states or Exchanges may not require eligible entities to obtain a producer license in order to become a Navigator.

Navigator certification should require thorough knowledge and understanding of the eligibility and enrollment requirements for QHPs offered through the Exchange, premium tax credits and cost-sharing reductions, and governmental programs, including Medicaid and the CHIP. In addition, Navigators should be trained to assist individuals in evaluating qualified health plans and selecting plans that meet their needs. The certification process could be similar to what states use to train counselors in their State Health Insurance Counseling and Assistance Program (SHIP) to assist Medicare beneficiaries. HHS should develop a training and certification program for Navigators for Exchanges to use. Development of such a program will ensure that Navigators receive uniform information on their responsibilities, as well as avoiding duplicative efforts by states and Exchanges.

Paragraph 155.210(b)(1)(iv) of the proposed rule requires that entities becoming Navigators must not have conflicts of interest, and the preamble asks whether additional requirements should be placed on Exchanges to make determinations about conflicts of interest. 76 Fed. Reg. at 41877. We recommend that the final rule specify that Navigators may not be health insurance issuers or any issuer-related entity, employees of any health insurance issuer or issuer-related entity or active health insurance brokers or agents.

We support the requirement in paragraph 155.210(b)(2) that an Exchange include at least two different types of entities in its Navigator program. In the preamble, the Department asks whether it should require that at least one of the entities serving as Navigators should be a community or consumer-focused non-profit organization. 76 Fed. Reg. at 41877. We support such a requirement with the modification that unions be included as one of the required entities. While unions are specifically listed as a separate entity in Section 1311(i) (2)(B) of the Act and the proposed rule, they are consumer-focused, non-profit organizations. Unions have a direct link to their members and can play a powerful role in helping members and their families learn about and enroll in qualified health plan coverage through the Exchange. Unions also have relationships with employers who may qualify to purchase coverage for their employees through the SHOP. The special role that unions play in negotiating health benefits, participating in the administration of multiemployer health plans and other benefit funds and assisting members enroll and obtain health benefits means they will be a trusted Navigator.

In paragraph 155.210(c), the proposed rule includes the statutory prohibitions in Section 1311(i)(4) of the Act that Navigators may not be health insurance issuers or receive any direct or indirect consideration from a health insurance issuer in connection with enrollments in any qualified health plan. In the preamble, the Department notes that “[t]hese provisions would not preclude a Navigator from receiving compensation from health insurance issuers in connection with enrolling individuals, small employers or large employers in non-QHPs” and asks for comment on this issue and “... whether there are ways to manage any potential conflict of interest that might arise.” 76 Fed. Reg. at 41877.

We oppose the interpretation offered in the preamble because it undermines the requirement that Navigators not have conflicts of interest. It is also difficult to envision how Navigators could comply with the requirement to “[p]rovide information and services in a fair, accurate, and impartial manner,” and broker health insurance to individuals and employers outside of the Exchange. The potential conflict of interest is, in our view, too great to manage. If Navigators sell health insurance plans outside of the Exchange, the advice they provide about plans offered in the Exchange may be influenced by their role as a broker or agent. For example, if a Navigator sells a particular issuer’s products outside the Exchange, the Navigator may be motivated to steer potential Exchange enrollees to plans from that same issuer, regardless of whether those products are in the best interests of the enrollees. Similarly, if Navigators receive higher compensation for enrollments in coverage available outside of the Exchange, they may be more interested in directing consumers to those products.

To avoid these types of conflicts of interest, the final rule should provide that Navigators may not be active health insurance producers in any health insurance market and may not receive direct or indirect consideration from any health insurance issuer for enrollments in plans available inside or outside of the Exchange.

In the preamble, the Department asks for comment on including a requirement that Exchanges have operational Navigator programs available no later than the first day of the initial open enrollment. 76 Fed. Reg. 41878. We support this proposal as Navigators can provide valuable assistance to consumers as they first learn about their health care coverage options and this assistance should be available throughout the initial open enrollment period.

Special Enrollment Periods §155.420

Section 155.420 of the proposed rule establishes special enrollment periods for the Exchange. Paragraph (b) provides the beginning date of qualified health plan coverage for individuals eligible for a special enrollment period. Paragraph (d) lists the events that will trigger a special enrollment period, and these events are consistent with the requirement in Section 1311(c)(6)(C) of the Act.⁸

⁸ Under Section 1311(c)(6)(C), the special enrollment periods under Section 9801 of the Internal Revenue Code are to be used as well as other periods similar to those provided under Part D of Medicare.

Under paragraph (b) of the proposed rule, the first day of qualified health plan coverage for individuals eligible for a special enrollment period will be generally be the first day of the month following the selection of a qualified health plan. However, special enrollees who select a qualified health plan after the 22nd of month may have to wait for the first day of the second following month for coverage to be effective.

The proposed rule allows for coverage gaps of one month or more if individuals become eligible for COBRA continuation coverage after the 22nd of a particular month. This delayed effective date is particularly problematic for individuals in the midst of treatment when they lose eligibility for employment-based coverage.

To address the potential gap in coverage, we suggest that the effective date of coverage for special enrollees be the date that they lost other coverage, provided they pay premiums back to that date. In addition, the final rule should permit individuals to begin the special enrollment process in advance of a known triggering event in order to avoid enrollment gaps.

Paragraph 155.420(d)(1) provides a special enrollment period when there is a loss of coverage and paragraph (e), in turn, provides two exclusions to the loss of coverage event, the failure to pay premiums, including COBRA premiums, on a timely basis and situations permitting a rescission from the loss of coverage. The discussion in the preamble expands upon what constitutes a loss of coverage, including a legal separation or divorce, end of dependent status, the termination of employment, and the termination of employer contributions. 76 Fed. Reg. at 41883. We recommend that these events, with the modification discussed below, be included in the body of the final rule rather than just discussed in the preamble. It would be appropriate to pattern the language after that used in the regulations under Section 9801 of the Internal Revenue Code (“Code”) which describe some, but not all, ways an employee or dependent could lose eligibility for coverage.⁹

The proposed rule, unlike the current Treasury regulations under Code Section 9801, does not provide that a loss of coverage triggering a special enrollment period occurs even if the individual is eligible for COBRA continuation coverage. The Treasury regulations on when the loss of eligibility results in a special enrollment period provide, in relevant part, that:

In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage).

26 CFR §54.9801-6(a)(3)(i). Example 3 in 26 CFR §54.9801-6(a)(3)(v) describes how an individual who loses eligibility may have two special enrollment periods with the first occurring

⁹ The applicable Treasury regulations at 26 CFR §54.9801-6(a)(3)(i) include the events discussed in the preamble.

with the initial loss of coverage and the second when COBRA continuation coverage is exhausted.

The final rule should follow the Treasury regulations and make clear that eligibility for COBRA continuation coverage does not prevent a loss of coverage.

Our suggested modification is consistent with the recently proposed regulations under Code Section 36B addressing the premium assistance credit.¹⁰ Under the proposed regulation, an individual eligible for continuation coverage will be considered ineligible for the credit "... only if the individual enrolls in the coverage." Proposed 26 CFR §1.36B-2(c)(3)(iv). In addition, our suggested modification provides workers who lose employer-provided coverage with the opportunity to enroll in coverage through the Exchange which may be more affordable than COBRA continuation coverage.

Paragraph 155.420(d)(6) provides an individual whose coverage under an eligible employer-sponsored plan will no longer be affordable or provide minimum value with a special enrollment period before coverage under that plan terminates. Allowing individuals in these circumstances to obtain an eligibility determination before the termination of coverage is appropriate. We suggest the special enrollment period begin with the date of the eligibility determination rather than either of the two other alternatives suggested by HHS. Beginning the 60-day period with the date the employee learns of the change could lead to making qualified health plan coverage effective earlier than necessary, while delaying the beginning date until the termination of coverage under the employer plan may lead to the gap in coverage that the proposed rule seeks to avoid.

Under proposed paragraph 155.420(e), the failure to pay premiums for COBRA continuation coverage is not considered to be a loss of coverage that triggers a special enrollment period. We suggest that this exclusion be eliminated or modified to permit a special enrollment opportunity for individuals who terminate their continuation coverage when it is not affordable.

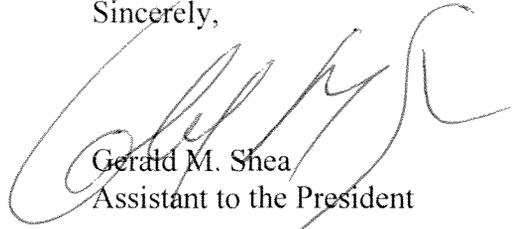
There are multiple instances where individuals enrolled in COBRA continuation coverage should be allowed to terminate that coverage and be able to enroll in a qualified health plan. For example, one of two working spouses loses a job and enrolls in continuation coverage. Several months later, the other spouse loses his/her job and the household can no longer afford continuation coverage premium payments. The enrolled spouse should be able to terminate continuation coverage and be eligible for a special enrollment period. Another example where termination of continuation coverage should be considered an eligible loss of coverage arises when continuation coverage premiums increase following enrollment. In light of the premium increase, an individual may be able to obtain more affordable coverage through the Exchange, particularly if he/she was eligible for the premium tax credit.

¹⁰ The proposed regulations issued by the Treasury Department and the Internal Revenue Service were published in the Federal Register on August 17, 2011 at 76 Fed. Reg. 50931.

Another circumstance to consider involves those individuals who became eligible for and enrolled in continuation coverage before January 1, 2014, when qualified health plan coverage will first be available. These individuals should not be prevented from enrolling in qualified health plan coverage because the qualifying event leading to the election of continuation coverage occurred before coverage through the Exchanges was an option.

We appreciate the opportunity to submit these comments to the proposed rule and we look forward to working with the Department as implementation of the Exchange provisions of the Affordable Care Act moves ahead. If you have any questions about these comments or need any additional information, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Gerald M. Shea', is written over the typed name and title.

Gerald M. Shea
Assistant to the President