COMMUNITY LEGAL SERVICES OF PHILADELPHIA

PENNSYLVANIA Health Law PROJECT

February 14, 2012

VIA E-MAIL (kkissinger@pa.gov)
Kari Kissinger, Director of Legislative Affairs
Pennsylvania Department of Insurance
1326 Strawberry Square
Harrisburg, PA 17120

Re: Comments on the Conceptual Draft of the Commonwealth Health Insurance Marketplace and Exchange Access Act (CHIMEAA)

Dear Ms. Kissinger:

We are writing in response to the conceptual draft of the Insurance Department's (the Department's) proposed legislation to establish state-based Health Insurance Exchanges under the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). We thank you for sharing the draft with us, and for providing us with an opportunity to comment on it.

Each year, Community Legal Services (CLS) helps more than 18,000 Philadelphians. We assists clients in establishing and maintaining eligibility for public benefits, including public health insurance programs, and we engage in systemic advocacy on our clients' behalf to ensure that public benefits programs are accessible, transparent, and effective. CLS also fights consumer fraud and predatory lending; prevents homelessness; ensures fair treatment in the workplace; and protects women, children, and the elderly. The Pennsylvania Health Law Project (PHLP) is a nationally recognized expert and consultant on access to health care for low income consumers, seniors, and persons with disabilities. PHLP engages in direct advocacy on behalf of individual clients statewide, answering 3,000 phone calls annually, while advancing health policy changes that benefit vulnerable Pennsylvanians. Our organizations believe that implementation of the ACA creates an unprecedented opportunity to provide comprehensive health insurance coverage to uninsured Pennsylvanians while addressing systemic barriers to public health insurance access.

We are concerned about the approach that the Department has proposed in its conceptual draft. We appreciate the Department's desire to create an Exchange that is unique to Pennsylvania, but the establishment of multiple private Exchanges is inconsistent with both the ACA and the approaches of all other states proposing state-based Exchanges. For this reason, we believe that it is unlikely to be approved by the U.S. Department of Health and Human Services (HHS). We urge a more conservative approach, because if the Department invests time and resources

pursuing this approach in the General Assembly, only to see HHS reject it, Pennsylvania will not have adequate time to advance alternative legislation to establish an HHS-approved state-based Exchange.

The conceptual draft also raises significant policy questions. Stated simply, multiple private Exchanges appear unwieldy for the Department to manage and for consumers to navigate appropriately. We also worry that the conceptual draft lacks necessary consumer protections and hallmarks of "good governance." Finally, we worry that the conceptual draft limits the Department's authority to adopt a package of health benefits that meets the needs of Pennsylvanians.

Below, we discuss these concerns in greater detail.

I. The Insurance Department's Conceptual Draft Is Inconsistent with the ACA.

A. The ACA Prohibits the Establishment of Multiple Private Exchanges.

1. Exchanges May Not Be Run by Private Entities.

We are concerned that the Department's proposed approach to ACA implementation is inconsistent with federal law. Section 103 of the Department's conceptual draft states that the term Exchange "shall include an Exchange operated directly by the Commonwealth or operated by an entity pursuant to contract or agreement with the Office of the Health Insurance Marketplace . . . ." Section 501 of the conceptual draft directs the Department to "certify any entity meeting the licensure and certification requirements of section §§§ to operate as an Exchange." We understand this language to allow for the wholesale delegation of Exchange duties to for-profit entities. This language is inconsistent with the ACA, and we fear that it may prompt HHS to reject the Department's approach to ACA implementation.

Section 1311(d)(1) of the ACA provides: "An Exchange shall be a governmental agency or nonprofit entity that is established by the State." In other words, under the ACA, Exchanges may not be run by private, for-profit entities; rather, they may be run only by states or designated nonprofit entities that were formed by states themselves. HHS reiterated this rule in the preamble to its proposed rulemaking on Exchanges and Qualified Health Plans, stating, "[W]e propose to codify section 1311(d)(1) of the Affordable Care Act that an Exchange must be a governmental agency or non-profit entity established by the State." 76 Fed. Reg. 41,866, 41,870 (proposed July 15, 2011) (to be codified at 45 C.F.R. pts. 155-56).

Of course, other language in the ACA does allow Exchanges to outsource some functions to private entities. Specifically, Section 1311(f)(3)(A) of the ACA states: "A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange." However, this language of "one or more responsibilities" does not permit states to contract out the *entire* operation of their Exchanges. Rather, this language permits states to assign specific, discrete functions of Exchange management – e.g., running call centers, providing information

technology functions, or handling appeals and fair hearings – while retaining the ultimate authority for the Exchanges as a whole. HHS's proposed rulemaking says as much, providing that, if states involve private contractors in Exchange functions, ultimate responsibility remains with the Exchanges. *See* 76 Fed. Reg. at 41,913 ("To the extent that an Exchange establishes [contracts with private entities], the Exchange remains responsible for ensuring that all Federal requirements related to contracted functions are met.") An alternative interpretation of Section 1311(f)(3)(A), that Exchanges may contract their entire operations to private, for-profit entities, renders Section 1311(d)(1) meaningless. Exchanges must be run by states or state-established nonprofits.

2. A State May Not Establish More than One Exchange per Geographic Region.

Because the Department's conceptual draft allows multiple Exchanges to operate in a geographic area, it does not conform to the requirements of the ACA. Section 1311(f)(2) of the ACA permits the establishment of "one or more subsidiary exchanges" in a state, but only if "each such Exchange serves a *geographically distinct area*" (emphasis added). The preamble to proposed HHS rulemaking explains this limitation further, permitting states to operate Exchanges in distinct geographical areas, as long as the Exchanges do not overlap:

> [T]he entire geographic area of a State must be covered by one or more Exchanges. A State could meet this requirement by having a combination of a regional exchange [that spans multiple states] and one or more subsidiary Exchanges, although to minimize consumer confusion, only one Exchange may operate in each geographically distinct area. To the extent that more than one Exchange is established in a State, we encourage each Exchange to ensure that consumers understand which exchange they should utilize to access health insurance coverage.

76 Fed. Reg. at 41,871. Thus, to comply with the ACA, states must ensure that each geographic area is covered by one, and only one, Exchange.

The Department's conceptual draft does not conform to the requirements of the ACA, because Section 501 would require the Department to "certify *any* entity meeting the licensure and certification requirements of section §§§ to operate as an Exchange" (emphasis added), apparently without regard for geographic area. This nonconformance with federal law will prompt HHS to reject the Department's proposed approach to ACA implementation.

The rationale provided by HHS for its restriction on multiple Exchanges operating in a single geographic area is "minimiz[ing] consumer confusion" and eliminating the potential for a scenario where consumers first must choose among several exchanges and then must select QHPs. As we discuss in greater detail in Section III.D, below, we feel strongly that the Department will serve consumers best by reworking its conceptual draft to conform to the plain language of the ACA.

B. The ACA Establishes Exchange Functions Missing in the Conceptual Draft.

The Department's conceptual draft is also inconsistent with the ACA because it does not require Exchanges to perform all duties established by federal law. Both the ACA and the Department's conceptual draft enumerate the responsibilities of Exchanges, but the enumerated duties are not aligned. For example, Section 1311(d)(4)(F) provides that an Exchange shall:

> inform individuals of *eligibility* requirements for the Medicaid program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, *enroll such individuals in such program* . . .

(emphasis added). In contrast, Section 504(d)(3)(ii) of the conceptual draft merely requires Exchanges to inform applicants for public health insurance "concerning eligibility for government programs" – no mention is made of enrollment. This inconsistency is particularly concerning for CLS and PHLP clients, who will overwhelmingly be eligible for and need to enroll in public health insurance programs.

Furthermore, the ACA establishes a number of Exchange functions that the conceptual draft lacks altogether. Section 1311(d)(4)(G) states that an Exchange shall "establish and make available by electronic means a calculator to determine the actual cost of coverage . . . ." And Section 1311 (d)(4)(H) requires an Exchange to, as applicable, certify that a consumer is exempt from the ACA's individual mandate to purchase health insurance. These functions are not enumerated in the Department's conceptual draft.

These missing functions from the Department's conceptual draft are required by federal law and protect Pennsylvania's consumers. Their absence will prompt HHS to reject the Department's approach.

II. The Model Proposed in the Insurance Department's Conceptual Draft Is Markedly Different from Any Existing State-Based Exchanges.

The Department's model of multiple private Exchanges differs markedly from Exchanges developed or proposed by other states. We appreciate the Department's efforts to craft a "Pennsylvania approach," but we urge caution. This departure from other states' approaches increases the likelihood that HHS will reject Pennsylvania's approach and result in the loss of precious resources (i.e., time and money) for implementing a state-based Exchange.

To date, fourteen states, plus Washington, D.C., have established Exchanges;[1] twelve Exchanges have been established legislatively, and two (Indiana and Rhode Island) have been established by

[1] Those states are: California, Colorado, Connecticut, Hawaii, Indiana, Maryland, Massachusetts, Nevada, Oregon, Rhode Island, Utah, Vermont, Washington, and West Virginia.

executive order. Like Pennsylvania, the states that have moved forward with state-based Exchanges have made the determination that they want to implement the ACA in a way that makes sense for their states, and they have customized their Exchanges accordingly. Four states have established state-run Exchanges, seven states have established quasi-governmental entities to run their Exchanges, and two states have established non-profit entities to run their Exchanges. Some states have separated the Exchange functions for individuals from the functions for small businesses. States have taken on varying approaches to establishing governance structures, certifying Qualified Health Plans (QHPs), defining Essential Health Benefits (EHBs) to the extent permitted by federal law, and soliciting stakeholder input.

The sole elements that other state approaches to ACA implementation and the establishment of state-based Exchanges have in common are these: none of the states plan to establish multiple private Exchanges that compete in the same geographical area, and none describe substantial subcontracting to private entities. Because the Department's proposed approach is such an outlier, relative to other states, we anticipate that HHS will reject it.

III. The Insurance Department's Conceptual Draft Raises Concerns about the Manageability and Accountability of Multiple Private Exchanges.

A. Multiple Private Exchanges Raise Concerns about the Accountability of Private Actors to the Department and to Pennsylvanians.

We have significant policy concerns about the establishment of multiple private Exchanges.

HHS will not approve a Pennsylvania model for state-run Exchange(s) absent details about how the Exchange(s) will comply with federal law. Pennsylvania's proposal must demonstrate how its Exchange(s) will conduct consumer outreach and education, operate a call center and an online portal for enrollment in QHPs, work with Navigators and producers, make eligibility determinations, exempt individuals from the individual mandate to purchase health insurance, certify QHPs, and manage the finances of the Exchange(s) responsibly. *See* U.S. Dep't of Health & Human Servs., Application for Approval of an American Health Benefit Exchange, Form CMS-10416 (proposed November 10, 2011). These responsibilities are extraordinarily complex. The development of just one Exchange will require significant investment in information technology infrastructure, data management and collection tools, marketing and branding, and privacy and security frameworks. We are deeply skeptical that multiple private Exchanges can meet these requirements in the allotted timeframe.

The Department's proposal gives it an extraordinary oversight task. Section 501(b) of the conceptual draft grants the Department the authority to conduct investigations and examine records of Exchanges or QHPs "as may be necessary to provide appropriate oversight." This language is vague and requires more detail as to how the Department would use its authority. How would the Department ensure that a multiplicity of private exchanges would comply with applicable state and federal law, particularly when the Department has acknowledged its own staff and resource limitations? For example, how would the Department ensure that Exchanges served CLS' and PHLP's low income clients without computer access or literacy, as required by

Section 1413(b)(1)(A)(ii) of the ACA? Adequate oversight of multiple Exchanges would be difficult, expensive, and inefficient.

Multiple private Exchanges would lead to other inefficiencies as well. Congress's vision of one or two Exchanges (if individual and small business functions of Exchanges are distinct) per state, as expressed in the ACA, intended for states to leverage their purchasing power. Multiple Exchanges would disrupt the economies of scale for establishing online enrollment portals, call centers, consumer materials and assistance, appeals and complaint processes, and information technology infrastructures that connect the Department, Medicaid and CHIP, and federal databases, resulting in costs that would be passed along to consumers.

Any Exchange should be required to report its activities at regular intervals to the General Assembly and the public. Section 504(d)(6) of the conceptual draft requires an Exchange to transmit information to the Department for purposes of reporting data to HHS, but the conceptual draft is silent as to how that information would be shared. The conceptual draft is also silent as to whether and by what metrics Exchanges would be measured for their ability to respond to the needs of Pennsylvania's consumers, and how those metrics would be publicized, to permit consumers to make educated decisions about which Exchanges to use. This reporting is absolutely essential for appropriate oversight and public accountability of private Exchanges, but it would be expensive with multiple Exchanges.

B. Multiple Private Exchanges Raise Concerns about Data Sharing and Data Management.

The ACA establishes privacy and security standards related to data flowing to and from Exchanges. For example, Section 1411(g) states consumers must provide only the information necessary to ascertain their identity and eligibility, and that the information may be used only for those purposes. Section 1413(c)(2) provides that consumers' private information may be ascertained via government and reliable third party data matching, but only if those consumers have applied for public health insurance programs or health insurance subsidies. And Section 1414(a)(1) authorizes the Internal Revenue Service to share federal tax information with Exchanges, but only to the extent necessary to determine consumers' eligibility for public health insurance programs or health insurance subsidies.

HHS acknowledges in the preamble to its proposed rulemaking that the ACA's privacy and security provisions are insufficient to appropriately govern the flow of data to and from Exchanges. 76 Fed. Reg. at 41,879. Accordingly, it has proposed more expansive rules to govern the privacy and security of information and limit how Exchanges collect, use, and disclose personal data. 76 Fed. Reg. at 41,916. Exchanges are required to "establish and follow security standards for collection, use, disclosure, and disposal of personally identifiable information" and to "establish and follow privacy standards consistent with applicable law." *Id.* Exchanges must also require *their contractors* to abide by their privacy and security standards, or standards that are more stringent. *Id.* (emphasis added).

Exchanges will be flooded with consumers' private data, and they will have significant discretion in determining how to protect and manage it best. The prospect that Pennsylvania will cede this discretion to private actors with significant financial interest in capturing and mining private data (e.g., Google or Microsoft) is extremely troubling. Even if the Department limits private Exchanges' discretion by promulgating its own privacy and security standards, we worry about its ability to enforce those standards given the multiplicity of Exchanges, the scope and breadth of the data to be protected, and the potential sophistication of some of the entities involved. We urge strenuously that the Department consider the integrity and security of consumers' data in formulating a final approach to establishing a state-based Exchange or Exchanges.

C. Multiple Private Exchanges Raise Concerns about Consumer Transitions between Private and Public Health Insurance Programs.

Because CLS and PHLP clients will largely be eligible for public health insurance programs, we are particularly concerned about the flow of data and other information between Exchanges and the Medicaid program and CHIP.

It is axiomatic that the incomes of families and individuals using Exchanges will fluctuate frequently. In some instances, these changes in income will be long term as with the loss of a job. In other instances, the changes in income may be due to temporary overtime income or additional seasonal employment. Examples abound: ski lift operators' income shifts as the ski season begins or ends, factory workers pick up overtime as manufacturing plants increase the number of shifts that they operate, and sales staff see an increase or decrease in commissions. Because many consumers experience these periodic fluctuations in income, their eligibility for public health insurance programs will change and they will move between public and private health plans.

The ACA and HHS's proposed rules on continuity of coverage explicitly address these transition issues to protect consumers from gaps in coverage. Section 1413 of the ACA directs HHS to work with states to develop coordinated eligibility and enrollment systems among Exchanges, Medicaid programs, and CHIP. In its proposed rulemaking on Medicaid eligibility changes under the ACA, HHS requires Exchanges to coordinate eligibility and enrollment for Medicaid and CHIP programs, as well as health insurance subsidies and Basic Health Plans, as applicable. 76 Fed. Reg. 51,148, 51,167 (proposed August 17, 2011) (to be codified at 42 C.F.R. pts. 431, 433, 435, & 437). HHS proposes to require that states establish coordinated eligibility and enrollment systems to ensure that Medicaid-eligible consumers are enrolled appropriately, no matter where their applications originate. 76 Fed. Reg. at 51,194-95. At renewal, if consumers are no longer eligible for Medicaid, state Medicaid agencies must transmit the data to the "appropriate program" for additional eligibility determinations. 76 Fed. Reg. at 51,193. This provision anticipates that consumers' data will be sent by Medicaid agencies to Exchanges for determinations of consumers' eligibility for health insurance subsidies.

As the Department implements these provisions of the ACA, CHIP's current interface with Medicaid provides several lessons about eligibility and enrollment coordination among health insurance programs.

From CHIP's inception, coordination between CHIP and the Medicaid program has been challenging at best. CLS and PHLP represent clients frequently who cope with these challenges when their household income changes and their children move from Medicaid to CHIP. We see that children often bounce between Medicaid and CHIP, never obtaining coverage from either program, because of a lack of proper coordination among multiple actors: the Medicaid eligibility and enrollment worker, the CHIP plan's eligibility and enrollment worker, the Medicaid HealthChoices enrollment broker, and the consumer.

The process for maintaining coverage through transitions between Medicaid and CHIP is further complicated by the nine different CHIP insurers that handle the eligibility, enrollment, and renewal processes. Levels of customer service vary among the insurers and state and federal rules around CHIP administration are not always interpreted consistently and correctly. In fact, at one point, the Department was concerned enough about quality control that it proposed centralizing eligibility and enrollment activities within the Department itself.

In recent years, CHIP and Medicaid coordination has improved with the passage of federal legislation that aligned program eligibility rules and the significant investment of staff time and technology at the state level to facilitate transfers between the programs. Even so, miscommunication between the programs leaves still children without coverage when rules are not correctly applied or other errors are made.

And coordination between CHIP and Medicaid is expensive. To achieve the improved yet imperfect system that Pennsylvania currently has, the Department has invested its finite resources in training for eligibility workers, studies of the breakdowns between the CHIP and Medicaid programs, the imposition of reporting requirements, and "Healthcare Handshake" technology.

CHIP has an enrollment of just 194,000 children. In contrast, public health estimates anticipate that 2.2 million Pennsylvanians will utilize the Exchanges in their first years of operations, and that 600,000 to 800,000 Pennsylvanians will be newly eligible for Medicaid.

With the lessons of Medicaid and CHIP coordination in our minds, multiplied by this enormous influx of new enrollees, we view compliance with Congress's and HHS's vision around the coordination of Pennsylvania's public and private health insurance systems under the ACA to be a daunting task. We believe that that task will become impossible if the Department moves forward with the establishment of multiple private Exchanges. *Each* Exchange would be required to invest in a technology infrastructure to coordinate with Pennsylvania's public health insurance programs, at great expense to the Exchange and the Medicaid and CHIP programs. The Department would have to monitor these infrastructures, with their divergent methodology and technology, on an ongoing basis. And even if the technology infrastructures could be established and maintained seamlessly, the creation of multiple private Exchanges creates additional, unnecessary complications. If consumers were disenrolled from Medicaid, to which Exchange would their data be sent? What if they preferred to do business with a competing Exchange? How would consumers know which Exchange to contact to choose QHPs to prevent

gaps in coverage? Who would consumers contact if the system broke down and their data was lost?

By injecting multiple private entities into the already daunting task of public and private health insurance coordination, the Department risks exposing low income consumers to gaps in health insurance coverage, duplication of coverage, and tax penalties or other financial consequences. For the protection of low income consumers, we urge the Department to rethink the feasibility of coordinating public and private health insurance programs through the use of multiple private Exchanges.

D. Multiple Private Exchanges Raise Concerns about Consumer Choice and Literacy.

Multiple private Exchanges will unnecessarily complicate consumer choice, particularly for consumers who are low income; have physical, mental, and/or intellectual disabilities; or have low levels of literacy and/or limited English proficiency.

Requiring consumers to choose an Exchange before deciding among many QHPs will be overwhelming, and will diminish the chance that they will obtain health insurance coverage that is appropriate for their needs. Together, CLS and PHLP have represented thousands of clients who have enrolled in Medicaid or CHIP MCOs or Medicare Advantage or Part D plans, and our concerns are rooted in their experiences. Consumers appreciate a manageable number of meaningful choices, but they are stymied by too much choice. Many of our clients successfully navigate choosing and enrolling in one of several Medicaid or CHIP MCOs, but they are paralyzed when they must choose among dozens of Medicare plans. These experiences are supported by research: a recent study in *Health Affairs* demonstrated that seniors enroll most successfully in Medicare Advantage plans if their choices are limited to fifteen plans or fewer. J. Michael Williams et al., *Complex Medicare Advantage Choices May Overwhelm Seniors – Especially Those with Impaired Decision Making*, 30 Health Affairs 1786 (2011).

An overabundance of choices particularly challenge low income populations because our clients, like nearly half of all Americans, have limited literacy skills. Studies show that one in five adults read at the fifth-grade level or below; for seniors and urban people of color, that number is two in five. Literacy levels are particularly low for recent immigrants and individuals with limited English proficiency. They are also low for individuals who are grappling with poverty, welfare, and unemployment – many of whom face these circumstances because they have disabilities. Consumers with limited literacy skills have particular difficulty in understanding and acting upon health information, especially because most health-related materials are written at a tenth-grade level or higher.[2]

[2] For a very helpful discussion of consumers' health literacy, see MAXIMUS, The Health Literacy Style Manual (2005), available at http://www.coveringkidsandfamilies.org/resources/docs/stylemanual.pdf.

The framework of the ACA is based on a model of consumer choice, and we appreciate the advantages inherent in that framework. Moreover, Congress and HHS have addressed consumer paralysis and low literacy concerns by establishing the Navigator program and requiring that Exchanges provide information in plain English and ensure meaningful access to information for individuals with disabilities and/or limited English proficiency. 76 Fed. Reg. at 41,916.

Most of the Pennsylvanians who using Exchanges will be low income individuals seeking public health insurance or health insurance subsidies, and they will have lower levels of literacy than the population as a whole. These consumers should not be burdened with privacy statements, disclosures, and the like for multiple Exchanges before they even get to the hard work of choosing appropriate QHPs or simply enrolling in Medicaid or CHIP. We urge the Department to consider the particular needs and limitations of low income consumers when it makes a final decision about how to best establish a state-based Exchange or Exchanges.

IV. The Insurance Department's Conceptual Draft Raises Concerns about Consumer Protections and Good Governance.

A. The Conceptual Draft Establishes an Advisory Council with Limited Consumer Representation.

Section 303 of the conceptual draft establishes a twenty-one member Advisory Council to advise the Department on a number of issues regarding the Exchange. The Advisory Council would be comprised of appointees with a range of interests. Pursuant to Section 303(g), it would be convened once per year, or more often as needed. Section 303(k) makes clear that the advisory council would have no true authority; rather, it would be "advisory only," and "may make recommendations to the [Department] as may be appropriate . . . ."

We recognize that the Advisory Council is not an Exchange governing board, but we are struck by how divergent the Council's duties are from the duties of the Exchange board as outlined in HHS's proposed rulemaking. For example, HHS anticipates that an Exchange board would be a governing board, presumably with actual authority, and that it would hold "regular" public meetings. 76 Fed. Reg. at 41,914. In addition, HHS plans to require Exchange boards to make public a set of guiding governance principles that includes ethics rules, conflict of interest disclosures, transparency standards, and disclosures rules. *Id.* We urge the Department to require the same of the Advisory Council.

Additionally, we appreciate the inclusion of consumer representation on the Advisory Council, but we are concerned that, pursuant to Section 303(b) of the conceptual draft, there would be only four consumer representatives on the Advisory Council: one representative who is not a medical provider or insurer, one consumer who purchases individual health insurance, and two small employers. In contrast, there would be three representatives of health insurers and two representatives of insurance producers. In light of the Department's stated goal of implementing the ACA in a manner that is as responsive to the needs and interests of consumers as possible, and in recognition that Pennsylvania is a large and diverse state, we encourage you strongly to

balance the number of consumer representatives with insurance industry representatives by establishing at least six consumer positions on the Advisory Council.

An increase in consumer representation on the Advisory Council would be consistent with HHS's assertion that "Exchanges are intended to support consumers, including small businesses, and as such, the majority of the voting members of governing boards should be individuals who represent their interests." 76 Fed. Reg. at 41,872. Moreover, it would allow the Department to reflect better the diversity of consumer interests. In its proposed rulemaking, HHS acknowledged that diversity, requiring Exchanges to "regularly consult on an ongoing basis" with a broad range of consumers and their representatives. 76 Fed. Reg. at 41,914.

In the conceptual draft, of the four proposed consumer representatives, two represent small employer interests. Two additional consumer representatives to speak for a multitude of consumer interests is inadequate. We recommend including a variety of consumer interests on the Advisory Council, including public health insurance recipients, individuals with disabilities, advocates for maternal and/or children's health, seniors, and consumers who purchase individual health insurance with and without subsidies. In addition, we urge you to establish a consumer subcommittee with a greater number of consumer voices that reflect the varying demographics of the Commonwealth, and that meets regularly and provides advice to the Advisory Council.

Finally, the conceptual draft is silent on the governance of private Exchanges. The Department should require all Exchanges create governing boards that meet in public, disclose their governance principles, and have adequate consumer representation and limited representation of industry interests.

B. The Conceptual Draft Does Not Clearly Establish Appropriate Roles for Navigators.

Section 1311(i) of the ACA establishes a Navigator program. Funded by Exchanges themselves, Navigators are charged by Congress to conduct public education activities and distribute "culturally and linguistically appropriate" information about QHPs, facilitate enrollment in QHPs, and refer consumers to appropriate resources for additional help. At the stakeholder forums that the Department convened in August 2011, our organizations provided recommendations for the establishment of a Pennsylvania Navigator program that will serve consumers best. We reiterate many of those recommendations below in the context of the Department's conceptual draft.

Section 510(a) of the conceptual draft prohibits persons from "sell[ing], solicit[ing] or negotiat[ing] the sale of a contract of insurance through the Exchange unless licensed as an insurance producer . . . ." We are concerned that this language would prohibit community organizations who will serve as Navigators, or who would perform Navigator-like functions (including CLS, PHLP, and COMPASS Community Partners), from facilitating clients' enrollment in QHPs or public health insurance programs.

Organizations like CLS and PHLP assist clients in applying for and retaining eligibility for Medicaid, CHIP, PA Fair Care, and other public or private health insurance programs. The assistance that we provide may be as limited as providing a client with an application and instructions on how to complete it, or as extensive as completing an application line by line and working with the client to collect and submit the requisite supporting documentation. We urge the Department to clarify the functions that community organizations may fulfill in facilitating enrollment for health insurance programs under Section 510(a), to avoid a chilling effect on the assistance offered, to the disservice of low income, disabled, and/or elderly consumers.

Section 510(b) directs the Department to establish a Navigator certification program for non-producers. While we understand the Department's desire to professionalize the Navigator program, we urge the Department to make the certification process manageable for community organizations who serve otherwise hard to reach populations, including organizations like Public Citizens for Children and Youth who have assisted families in enrolling in Medicaid and CHIP for almost twenty years. If the Navigator certification process is overly cumbersome, we fear that many community groups may decide that it is not worth the time and trouble to become Navigators. In fact, because many consumers are more comfortable approaching community organizations rather than producers or other for-profit entities, we urge the Department to ensure that every geographic area has one or more community organizations acting as certified Navigators.

Section 510(c) directs the Department to establish an alternative path to Navigator certification for producers. We have real qualms about the conflicts of interest inherent in allowing producers, who have longstanding financial relationships with QHP issuers, to serve in Navigator roles. But if the Department is committed to allowing producers to act as Navigators, it must be clear that producers are not permitted to receive remuneration from QHP issuers while serving as Navigators. Specifically, Section 1311(i)(4)(i) of the ACA prohibits Navigators from receiving "any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a [QHP]." We urge the Department to incorporate this limitation into the language of the conceptual draft.

Section 510(d) permits Navigators to assist eligible consumers in enrolling in public health insurance programs. The ACA is silent as to whether Navigators must enroll consumers in public health insurance programs, and we appreciate that the Department would permit them to do so. However, we believe that the conceptual draft should be even firmer, and *require* Navigators to facilitate the enrollment of eligible consumers in public health insurance programs. While we expect that many community organizations who are Navigators will choose to enroll consumers in the public health insurance programs for which they are eligible, some eligible consumers will seek out producers and other private entities instead. Those consumers should receive the same level of service as consumers who visit community organizations.

C. The Conceptual Draft Limits Unduly Proper Checks on Executive Authority.

Section 707(b) of the Department's conceptual draft exempts the Department's promulgation of regulations from the Commonwealth Documents Act, the Commonwealth Attorneys Act, and the

Regulatory Review Act for three years from the effective date of the Act. We are troubled deeply by this provision.

These three Pennsylvania laws provide an essential check on Executive authority. They also afford the General Assembly and the public with the opportunity to provide vital input. Moreover, they require that proposed regulations go through a rigorous review process. The Regulatory Review Act is of particular importance, as it requires agencies to file proposed, final-form, and final-omitted regulations with the Independent Regulatory Review Commission, with thirty-day public and legislative committee comment periods following each filing. *See* 71 P.S. § 745.5-5a (2012).

We appreciate the need to proceed swiftly with ACA implementation, but we are extremely concerned about a suspension of the regulatory review process that would last for three years. We know of no other law of such importance and magnitude with such a broad and lengthy exemption from these critical checks on Executive power. The Commonwealth Documents Act, the Commonwealth Attorneys Act, and the Regulatory Review Act contain provisions already that would allow the Department to "fast track" rulemaking, affording it an opportunity to move quickly while safeguarding the public's and legislature's right to participate in ACA implementation on an ongoing basis. If the regulatory review process were to be suspended for any length of time, we urge the Department to establish appropriate mechanisms to publicize rules and regulations and to receive, consider, and incorporate comments from legislators, consumers, and other stakeholders.

D. The Conceptual Draft Unduly Limits Liability and the Scope of the Pennsylvania's Right-to-Know Law.

The conceptual draft legislation would limit severely the legal liability of almost every entity or agent involved in the governance, oversight, and management of Pennsylvania's Exchanges.

Most troublingly, Section 706(a) of the conceptual draft states:

> [T]here shall be no liability on the part of and no cause of action of any nature against the Commissioner, Department, the Office, an Exchange, any insurer, producer, navigator, or authorized representative, agent or employee for the use by any of them of any information furnished to it pertaining to:
>
> (1) An application for, inquiry concerning, or enrollment or disenrollment in a health insurance policy or government program, including an inquiry regarding eligibility for enrollment or eligibility for a government program, relevant to health insurance available through an Exchange or health care coverage or other benefits through a governmental program.
>
> (2) A charge, assessment, or imposition of a fee received from any person or entity relevant to an Exchange.

As drafted, this provision is so encompassing that it would have the effect of excusing both governmental and private parties from any liability whatsoever. This limitation on liability is far

too broad. If the Department envisions Exchanges run by private entities that will profit from their involvement, then those private parties should be expected to bear the risk of any wrongdoing. Consumers should be able to challenge private operators of Exchanges, producers, and other actors who willfully and intentionally give erroneous information, especially if that information results in temporary or permanent damage to the consumers' health or finances. Even worse, Section 706(a) could be read even to exempt private parties from criminal liability. Consumers should be able to rely on the legal system for remediation if Pennsylvania's Exchange(s) harm them.

Section 706(a) departs sharply from consumer protections in other states. Specifically, Exchange legislation in at least four states (California, Massachusetts, Connecticut, and Colorado) establishes private rights of action for consumers while protecting board members, officers, or employees for acts or obligations entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with administration, management or conduct of the board's business, except for willful dishonesty or intentional violation of the law. The same states have addressed criminal liability. The Department should follow their example by revising the draft legislation to include conditional liability for willful, fraudulent, or criminal actions by private entities in connection with the operation of a Pennsylvania Exchange.

Furthermore, we are troubled deeply by the limits on Pennsylvania's Right-to-Know Law (RTKL), 65 P.S. §§ 67.101-3104 (2012). The RTKL establishes public access to the public records of Commonwealth agencies, local agencies, courts, and legislative agencies. The term "public record" includes financial records (e.g., accounting records and contracts) of an agency. § 67.102. Under the RTKL, all records are presumed to be public unless disclosure is barred by state or federal law or regulation, or judicial order; privilege; or one of the limited exceptions. *Id.*

Section 506(c) of the Department's conceptual draft makes confidential and privileged, not subject to the RTKL, and not discoverable in a private civil action, any documents, materials or other information in the control or possession of the Department that is part of an investigation or examination. The terms "investigation" or "examination" are not defined by the conceptual draft, so it is possible that *any* documents could be protected from public scrutiny under the RTKL or in civil litigation simply by asserting that they are connected to a purported investigation or examination.

Moreover, Section 506(c)(2) prohibits Department staff and *any* person acting under the authority of the Department who receives protected documents, materials, or other information from testifying in *any* private civil action relating to the protected items. Under Section 506(5)(i), final, adjudicated actions appear to be the only matters subject to public inspection.

These confidentiality provisions are simply too broad, and they are unprecedented. Other states (California, Massachusetts, Connecticut, and Colorado) have subjected their Exchanges to their respective states' open records laws. We urge Pennsylvania to follow suit and revise Section 506(c) of the conceptual draft to make clear that documents, materials, and information related to the governance, activities, operations, and functions of Pennsylvania's Exchange(s) will be subject to the RTKL (with private health and legal information redacted, of course). Anything

less than full conformity with RTKL opens an Exchange to suspicion and distrust, undermining its effectiveness and integrity as a fair and valued marketplace.

V. The Insurance Department's Conceptual Draft Limits its Authority to Develop Benefits Packages that Meet the Needs of Pennsylvanians.

As a final point, we are concerned that the Department has limited unnecessarily its authority to develop an EHB standard that is responsive to the needs of Pennsylvanians. Section 1311(d)(3)(B)(i) of the ACA gives states the authority to require that QHPs offer benefit packages that are more robust than the EHB standard specified by HHS. Yet Section 505(a) of the Department's conceptual draft states: "Notwithstanding any provision of state law, a qualified policy offered on an Exchange shall not be required to cover benefits other than the essential health benefits specified pursuant to the [ACA]." We read this provision as explicitly rejecting the authority granted by the ACA.

The Department should not restrict its authority to tailor an EHB standard to the particular needs of Pennsylvanians. It is true that both Section 1302(b)(5) of the ACA and Section 505(b) of the conceptual draft grant *QHP issuers* the authority to exceed the federal EHB standard. However, the Department may feel compelled to exceed the federal EHB standard *itself*, for two reasons. First, it is wholly unclear what the federal EHB standard might look like, as, to date, HHS has issued only preliminary subregulatory guidance that is subject to revision. At some point, the Department may determine that the federal EHB standard is unsatisfactory and insufficient. Second, when defining both Medicaid and CHIP benefits packages, Pennsylvania has chosen to offer more robust benefits packages than required by federal law, in recognition of the particular health insurance needs of its residents. In light of the uncertainty around the federal EHB standard and its own past precedent, we urge the Department to retain the authority to require that QHPs provide benefits above the floor set by HHS.

Thank you very much for reviewing our comments. We would welcome the opportunity to discuss them further with you and your colleagues. You may reach us by contacting Kristen Dama at (215) 981-3782 or at kdama@clsphila.org, or by contacting Ann Bacharach at (215) 626-3596 or at abacharach@phlp.org.

Sincerely yours,

Kristen M. Dama, Staff Attorney
Justine Elliot, Staff Attorney
Richard P. Weishaupt, Senior Attorney
For Community Legal Services

Ann Bacharach, Special Projects Director
Laval Miller-Wilson, Executive Director
For the Pennsylvania Health Law Project