



Oregon

Kate Brown, Governor

Department of Consumer and Business Services

Director's Office
350 Winter Street NE, Room 200
P.O. Box 14480
Salem, OR 97309-0405
503-378-4100
Fax: 503-378-6444
www.dcbs.oregon.gov

December 21, 2015

Submitted Electronically Only (www.regulations.gov)

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9937-P
P.O. Box 8016
Baltimore, MD 21244-8016

To Whom It May Concern:

I write this letter on behalf of the State of Oregon Department of Consumer and Business Services (“the Department” or “we”) to comment on the proposed *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017* regulations published in the Federal Register on December 2, 2015.

The Department has been committed to implementation of the Affordable Care Act since its passage. In 2011, the Department proposed and successfully shepherded ACA legislation that made Oregon one of only a handful of states to adopt laws implementing the early reforms. In the spring and summer of 2012, the Department helped lead a six-month statewide, public process to adopt an ACA benchmark plan and led a similar process through the fall and winter of 2012 to design metal-level versions of standard essential health benefit plans so consumers have health insurance options that can be compared “apples-to-apples.” In 2013, the Department spearheaded passage of significant legislation to implement the 2014 market reforms and conducted a four-month rulemaking to issue implementing rules. In 2015, the Department took over the functions of Cover Oregon and now operates both the State’s Insurance Division and State-Based Marketplace. Broad stakeholder involvement, interagency cooperation, and process transparency have been and continue to be key to the Department’s successes.

General Comments

We appreciate the opportunity to comment on these regulations but are concerned with the amount of time we were allowed for comment. We believe that the complexity of this proposed rule merits the full comment period time of 60 days. Executive Order 12866 appears applicable to this draft: “each agency should afford the public a meaningful opportunity to comment on any proposed regulation, which in most cases should include a comment period of not less than 60 days.”

The 30 days from public exposure and 19 days from publication in the *Federal Register* for public review and comment were insufficient in our view given the hundreds of policy and process changes that must be carefully considered not only for their own merits, but also for their impact on other regulations.

Comments to Proposed Amendments

45 CFR § 147.102(b) (page: 75496) Fair Health Insurance Premiums, Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

The Department does not support proposed changes to the methodology for establishing rating areas. Disruptions to established rating areas may inadvertently cause consumers in rural areas to subsidize premiums for consumers in urban areas. HHS should continue to allow states to establish rating areas consistent with identified geographic and social factors within the state rather than arbitrarily specified percentages. The Department believes established rating area regulations should not be changed.

45 CFR § 147.104(e) Guaranteed Availability of Coverage (page 75496)

The Department supports the proposed exception to guaranteed availability when insurers are discontinuing a product or all products in a state.

45 CFR § 147.145(b)(4) Actuarial Value Requirements for Student Health Insurance Plans (page 75498)

The Department disagrees with the proposed exemption to actuarial value requirements for student health insurance plans. Individuals enrolled in student health benefit plans may rely on insurance coverage available through their university to provide comprehensive coverage. Removing actuarial value parameters consistent with products in the individual market may encourage colleges and universities to reduce coverage options for students. Actuarial values are an important measure for consumer as they are a key indicator for anticipated out-of-pocket costs and may be important for students trying to decide between purchasing a plan on the individual market or staying with their parent's employer sponsored insurance, rather than purchasing the student health plan option.

Insolvent Issuers (page 75514)

In general, the Department agrees with HHS proposals in cases where a health insurance issuer becomes insolvent or exits a market midyear and both the entity seeking to acquire business from an insolvent issuer and the insolvent issuer lack a full year's data to submit for the risk adjustment or reinsurance programs. However, the majority of Oregon's domestic industry are Health Care Service Contractors ("HCSC"), not "insurers," and are therefore not subject to the guaranty association to pay claims. In this case, the provider is required to include in their contracts a "hold harmless" provision, that forces the provider to not seek payment from a consumer for what should have been covered under their insurance policy, if the HCSC becomes insolvent. We propose including providers, in the same manner as the guaranty associations are noted here.

The Department also recognizes, that due to the volume of claims and relatively small dollar increments compared to the aggregate data from an insurer, this may be very difficult logistically

on both the provider and HHS sides, especially considering the differences between the claims processing from a provider perspective and the insurer/HCSC perspective. Additionally, there are some concerns about double payment of these amounts, which we do not believe is the intended purpose, but in some cases, the receipt of the payments from HHS by an insolvent insurer (while in supervision/runoff/receivership) would help to facilitate the payment of claims during the runoff of the company.

45 CFR § 155.106(c) Election to Operate an Exchange After 2014 (page 75517) - From “We propose to add a paragraph (c)” to the end of the column.

The proposed “critical path” timeline is not a realistic one to either submit a new Blueprint or update an existing one AND get an approval for an operational readiness assessment. We propose the following: “These States must submit an Exchange Blueprint (or submit an update to an existing approved Exchange Blueprint) at least 6 months prior to the date open enrollment is to begin for the State as an SBE-FP.”

The proposal should also include a timeline from when the Federal platform agreement must be fully executed and a transition plan is approved. I recommend that this be done at least 2 months before the start of OE so that the State and its citizens have sufficient time to undergo outreach and education to lessen barriers to enrollment.

45 CFR § 155.170 Additional Required Benefits (pages 75517-8)

The Department is concerned that guidance provided in the interpretation of law may be inadvertently interpreted by insurers as a new mandate. This language needs to be clarified that sub-regulatory guidance is not considered a mandate. The proposed phrase “state action” is overbroad and exceeds the boundaries of Section 1311(d)(3)(B) of the Affordable Care Act, which refers only to what the “State may require.” Statutes and regulations are state requirements. Sub-regulatory guidance is not a state requirement but rather a state interpretation of what statutes and regulations require.

We agree with the approach outlined in 155.170(a)(3) and (c)(2)(iii) because we believe the state is in the best position to determine which of its agencies is best-suited to conduct the mandate analysis. In some instances, this may in fact be the state-based marketplace.

We disagree with the statement on page 75518 regarding section 1252 of the Affordable Care Act (ACA). Section 1252 specifically relates to rating reforms. Even if Section 1252 applied more broadly to include state benefit mandates, its application is limited to state benefit mandates required by, or adopted pursuant to, Title I of the ACA. Very few, if any, state-mandated benefits fall into these categories.

Moreover, section 1311(d)(3)(B)(i) and (ii) very specifically limit the requirement of a state to defray the cost of additional benefits that are required of a *qualified health plan*. If section 1252 prohibited states from mandating benefits for only plans that are not qualified health plans, then it would render meaningless section 1311(d)(3)(B)’s specific application to qualified health plans. This is only one example of Congress’s intent to make distinctions between qualified health plans and health plans that are not qualified health plans.

45 CFR 155.200(f)(1) General Functions of an Exchange (pages 75518-19)

The proposed regulation indicates a general federal platform agreement for all states operating as a SBE-FP. The language found in the proposed regulation indicates the document may not be negotiated on a state-by-state basis. This agreement approach may present concerns for state procurement and contracting officials who may require state specific contract language. In addition, SBE-FP states may differ in the federal services they use. The Department does not support the proposed rule and requests that the rule not be adopted and that HHS follows usual contracting procedures for each state.

45 CFR 155.200 General Functions of an Exchange (page 75519)

The proposed regulation states that “SBE-FPs may exceed these minimum standards to the extent they do not present display problems on HealthCare.gov.” In some circumstances insurers begin plan development 18-months prior to the start of a plan year. The Department is concerned that these standards will not be communicated with sufficient time to direct insurers in SBE-FP markets. The Department does not support the proposed regulations that would adjust the plan and filing requirements for plans offered in a SBE-FP and rejects the assumption that members will be confused by other state regulations when shopping on healthcare.gov. The requirements to use the HICS system and utilize HHS as a routing mechanism for complaints creates procedural burdens on state based consumer advocacy staff. Consumer complaints for SBE-FPs should be referred directly to the appropriate state authority for resolution. Finally, the Department does not support providing HHS authority to suppress plans without prior approval from state regulators. The rule states: “The SBE-FP would retain responsibility for plan management functions . . .the SBE-FPs would retain primary, formal responsibility for overseeing QHPs and issuers , . . .” this includes any necessary plan suppression. The state is obligated to perform these regulatory functions and is in the best position to understand the issues with its issuers.

45 CFR § 155.205(a) Consumer Assistance Tools and Programs of an Exchange (page 75519)

We support this proposal. We believe our resources can be better put to use focusing on Oregon-specific issues, providing tailored customer service to consumers and partners, and focusing on in-person community outreach.

Standards Applicable to Navigators under 155.210 and 155.215; Standards Applicable to Consumer Assistance Tools and Programs of an Exchange (155.205)(d) and (e); Navigator Assistance Personnel in an FFE and to Non-Navigator Assistance Personnel Funded through an Exchange Establishment Grant (155.205, 155.210, & 155.215) (pages 75520-24):

45 CFR § 155.210(e)(8), and (9)

We support the proposal to require navigators to provide targeted assistance to vulnerable or underserved populations. This is something that we’re already doing through the selection process of the community partner organizations to which we provide outreach and enrollment grants. We also support the proposal to require navigators to provide post-enrollment assistance, which is something that most of our partner agencies already do. We, however, caution that this may increase the scope of work for some partners who may already be struggling to maintain their insurance outreach and enrollment programs without this increased scope of work.

45 CFR § 155.210(b)(2)(v) – (viii)

We oppose requiring these activities due to the financial burden on insurance outreach/enrollment programs that these additional requirements would impose. We support making these activities optional and leaving it to the organization to determine if it has the resources and staff necessary to perform the activities. We oppose the provision that requires navigators to investigate denied claims due to the same concerns. Consumers have the resources of the issuer’s regulatory agency and may also seek the assistance of an agent to assist with claim denials.

First full paragraph on page 75523

We support making these activities optional and leaving it to the organization to determine if it has the resources and staff necessary to perform the activities. We oppose the provision that requires certified application counselors to investigate denied claims due to the same concerns. Consumers have the resources of the issuer’s regulatory agency and may also seek the assistance of an agent to assist with claim denials.

45 CFR § 155.205(d) and 155.215(b)

We oppose this proposal. Outreach and enrollment programs often have to “hit the ground running” with outreach activities, and the FFM training is onerous and often has technical problems. Preventing them from doing outreach before completing the training is unnecessary, as outreach often involves, particularly at the beginning of open enrollment, just reminding consumers to look at their insurance options again, without providing heavily detailed specifics that may require training.

45 CFR § 155.210(d)(6) and 155.225(g)(4)

We support these proposals. Gifts of nominal value can be key to successful outreach and may increase contact between assister staff and consumers without serving as enticement to enroll.

45 CFR § 155.220 New Exchange Standards for Web-Brokers - First full paragraph on page 75525

CMS proposes to change the current rules requiring web-brokers to start a consumer application in their proprietary portal, then transfer to the exchange website to complete the application. The proposal is to allow the entire transaction to take place in the web broker’s portal. Assuming CMS takes appropriate steps to protect consumer information, the Department supports this proposal because it simplifies the process for consumers.

45 CFR § 155.220 New Exchange Standards for Web-Brokers - Last paragraph of first column to “ii” in second column on page 75525

CMS proposes increased monitoring and oversight with respect to privacy and security for those consumers who enroll with web brokers. Considering the myriad of consumers doing business on the Internet, additional security is an appropriate consumer protection and we support this proposal.

45 CFR § 155.220(g)(2)(ii), (g)(5), and (g)(4) New Exchange Standards for Web-Brokers (pages 75525-26)

CMS proposes to establish standards for termination of agents' access to the exchange for violating terms on use of the exchange. This does not pre-empt states from regulating agents under current practice. We support this proposal because it provides additional protection to Marketplace consumers.

Last paragraph of first column on page 75526 to “iii” in second column

Sets standards for suspension of agents violating terms on use of the exchange. Proposes a 90-day suspension period, which currently does not exist. We support this proposal because it provides additional protection to Marketplace consumers.

45 CFR § 155.220(j) FFE Standards of Conduct for Agents and Brokers (pages 75526-27)

CMS proposes to add standards of conduct for agents assisting consumers on the exchange. Standards include providing correct information and no marketing that is misleading or coercive.. Agents will need to sign an agreement acknowledging these standards prior to using the exchange. Violations of standards will result in termination from use of exchange. The Department supports the proposal allowing the termination of exchange use for agents violating these standards because it protects consumers and will not be a burden to agents following compliance standards.

However, the Department is concerned that cases of misconduct will not be referred to the appropriate regulatory authority and believes that all allegations of agent misconduct in SBE-FP states should refer to the state. It would be helpful if CMS stated that in case of agent misconduct (including fraud, improper use, and disclosure of information) the case would be referred to the appropriate state regulatory authority immediately after agent exchange termination. States have conduct regulations and structures that address agent misconduct regardless of whether or not the product was sold on or off of the marketplace. State regulators may want to investigate agent misconduct to see if additional consumer harm has occurred in off-exchange sales.

45 CFR § 155.222 Standards for HHS-Approved Vendors of FFE Training for Agents and Brokers (page 75527)

The Department believes that specific marketplace training materials may be beneficial for agents. However, we are concerned that specific FFM training requirements may not address state specific regulations and propose that training materials should be made available for voluntary incorporation by individual SBE-FP.

45 CFR § 155.225 Standards Applicable to Certified Application Counselors (pages 75528-29)

We support this proposal, as this information is already being collected by community partner organizations providing application assistance. We suggest that monthly reporting include number of certified assisters available at the organization, number of applications submitted for both Qualified Health Plans and Medicaid/CHIP programs, total instances (rather than number of individuals helped, as consumers may require multiple contacts) of application assistance provided by an organization in a given reporting period, as well as number of estimated outreach contacts within that period. This reporting format and these categories are currently in use in Oregon and required of our partner organizations.

Medicare Notices (pages 75530-31)

For Medicare individuals a “pop up” on Healthcare.gov is a good starting place; however, in working with the Medicare population they are more likely to take action if they receive a letter (not on their account, an actual hard copy letter). Start with the “pop up” as a reminder during the enrollment process. If the individual enrolls, a paper notice should be sent 30 days prior to the individual’s 65th birthday, advising: (1) You may be eligible for Medicare on your 65th birthday. Once you’re eligible for Medicare, you’ll have an initial enrollment period to sign up for Medicare. For most people, the initial enrollment period starts 3 months before their 65th birthday and ends 3 months after their 65th birthday; (2) You must notify the Marketplace if you are ending your QHP coverage; (3) If you enroll in Medicare Part A and keep your QHP coverage through the Marketplace you will have to pay back any APTC you received while enrolled in both plans as you are no longer eligible for APTC; and (4) If you enroll in Medicare after your initial enrollment period ends, you may have to pay a late enrollment penalty for as long as you have Medicare. In addition, you can enroll in Medicare Part B (and Part A if you have to pay a premium for it) only during the Medicare general enrollment period, and depending on when your enrollment period is in the year, this may create a gap in your coverage.

45 CFR § 155.335(j) Annual Eligibility Redetermination (page 75531)

In general, we support the proposal’s goal of maintaining an individual’s eligibility for cost-sharing reductions by re-enrolling an individual in a silver-level plan. However, the Department does not support HHS’s proposal to automatically enroll individuals in a plan of another insurer. The Department monitors plan enrollment for some insurers to determine financial capacity and prevent insurers from receiving large enrollments. Allowing automatic reenrollment into another insurer may place capacity strains on insurers and prevent state regulators from effective financial enforcement. In addition, the new insurer may have significantly different provider networks than the consumer is used to.

45 CFR § 156.230 Network Adequacy Standards (pages 75549-52)

In general, the Department seeks state flexibility in defining network adequacy standards, in order to adapt to innovations in our market while continuing to provide consumers with adequate access to care when we can demonstrate that our own state standards provide equal or greater consumer protection.

Minimum threshold

In 2015, Oregon passed legislation charging the Department of Consumer and Business Services to further network adequacy requirements in the individual and small group markets in the state, beyond the federal requirements. Specifically, Oregon has convened a diverse and representative advisory committee to develop factors to be used by health insurance carriers to demonstrate the adequacy of their provider networks, including those that address: consumer satisfaction, transparency, quality of care and cost containment, and access to care consistent with the needs of the enrollees served by the network. The committee will also recommend one or more nationally-recognized network adequacy standards such as the NAIC’s Network Adequacy Model Act and Medicare Advantage for use as an alternative way to prove networks are sufficient. The committee will make recommendations for rules that go into effect in 2017.

Provider transitions

The Department appreciates the proposed rule requiring QHP issuers in all FFEs to notify enrollees about a discontinuation in their network coverage of a contracted provider. We recommend that QHP issuers be required to notify all patients assigned to the provider if it is their primary care provider or if the patient has been referred to or is actively undergoing treatment by the provider. We also recommend that issuers be required to notify patients 30 days prior to the effective date of the change. We would also encourage issuers as part of the notice to notify the enrollee of other comparable in-network providers in the enrollee's service area, provide information on how an enrollee could access the plan's continuity of care coverage, and encourage the enrollee to contact the plan with any questions.

The Department also supports the proposed rule to ensure continuity of care for enrollees in cases where a provider is terminated without cause and that the services received under the continuity of care provision be provided at in-network rates. We recommend that the definition of "termination without cause" incorporate cases where the provider's contract is non-renewed or whether we should consider a non-renewal of the provider's contract as a termination without cause under §156.230(e)(1) and (2). Oregon has its own definition for continuity of care that is stronger than the federal definition and is satisfied with the proposed rule, provided the definition of "active treatment" establishes a minimum floor.

45 CFR § 155.400 Rules for First Month's Premium Payments for Individuals Enrolling with Regular, Special, and Retroactive Coverage Effective Dates (pages 75531-32)

We agree with the approach outlined in 155.400(e)(1)(i) and (ii) because it aligns the requirements for enrollments with prospective special effective dates with the requirement for enrollments with regular effective dates. We believe that greater consistency is easier for consumers to understand and easier for issuers to administer.

We also agree with the approach suggested in 155.400(e)(1)(iii) to limit the risk to issuers associated with the issuance of retroactive coverage. We believe this approach balances the needs of consumers and the needs of issuers.

45 CFR § 155.400 Reliance on HHS to Carry Out Enrollment and Related Functions (page 75532)

We agree with this proposal, but seek to clarify that HHS is to implement the functions related to eligibility and enrollment in the *individual market*.

45 CFR § 155.510 Appeals Coordination (p.75534)

We support this proposal. While this may be a duplication of efforts for the appellant, this procedure should significantly speed up the appeals process, resulting in more advantages for the appellant.

45 CFR § 155.545 Appeal Decisions (page 75535)

We have no comment on the proposal; however, we reiterate that HHS should look for a solution to the "family glitch."

Under current law, an employee's employer-sponsored coverage that meets the minimum value standard and is affordable for the employee, is deemed affordable for the household (family), making all household members ineligible for exchange financial assistance. This creates three potential issues:

(1) If the employer offers coverage to the entire family and only contributes to the employee, the remaining family member's premium in many circumstances may be unaffordable, even though it is considered affordable per the ACA; (2) Employers offer coverage to the employee only and no longer offer to the entire household, leaving the family enrolled on different plans (this may open the door for financial assistance through the Marketplace); or (3) The "Small" employer stops offering employer coverage altogether to avoid paying for the entire family and/or to allow the employee and the family to use the Marketplace.

45 CFR § 155.555 Employer Appeals Process (page 75535)

In this scenario, when the HHS rules in favor of the employer and the employee loses his/her eligibility for APTC, the employee will also be required to report this change in eligibility (aka "change in health coverage"). Since this particular type of life change would typically trigger the employee to cancel his/her Marketplace plan, the employee will need to cancel as soon as he/she knows when the employer coverage will start.

The employee will also be held liable for the two additional weeks of premium payments (<https://www.healthcare.gov/reporting-changes/cancel-plan/>). We suggest that the regulation require the notice to specify when the APTC will be removed and to let the employee know that if he/she waits too long to cancel the Marketplace plan, the 14 days of premium payments to the insurance company will be significantly higher.

Additionally, the notice should specify the date the employee can begin coverage under an employer-sponsored plan. This will help ensure that the employee doesn't have a gap in coverage and will provide the employee with the information he/she needs to plan accordingly.

45 CFR § 155.605 Eligibility Standards for Exemptions (pages 75535-37)

We support this more streamlined approach for consumers; however, a three-year hardship exemption seems excessive. We suggest that a two-year exemption is adequate.

45 CFR § 155.705 Functions of a SHOP (pages 75539-40)

CMS proposes to add a 'vertical choice' under SHOP which would allow employers to offer employees a choice of all plans across all available level of coverage from a carrier. They also propose aligning these same provisions for the states using the federal exchange as Oregon does. We support this approach because the additional choices for employees may enhance the appeal of SHOP for both employees and employers.

45 CFR § 155.1000 Denial of Certification (pages 75541-42)

We agree that 155.1000 gives Exchanges broad discretion to certify qualified health plans. However, we seek to clarify that state-based Exchanges, including SBE-FPs, have the ultimate authority to certify qualified health plans on state platforms and the FFE platform. In other words, we do not agree that HHS has the authority to deny certification to a qualified health plan

on a state platform or the FFE if the qualified health plan is otherwise certified by a state-based exchange or SBE-FP respectively.

45 CFR § 156.20 Standardized Option Definition (page 75542)

We welcome the introduction of optional standardized plans. However, to the extent that such plans ever become required, we have reservations. Oregon currently requires all health benefit plan issuers to offer state-designed standard plans and is considering limiting the total number of qualified health plans an issuer may offer through the Marketplace. Should federal standard plans be required in the future, we ask that states be given the option to choose to require issuers to offer state-designed standard plans in lieu of federal standard plans.

Deductible-Exempt Services (page 75543)

We agree with the exemption of primary care visits and generic drugs from the deductible because of the value the exemption provides to consumers and because these exemptions ultimately promote better health. We agree with the exemption from the deductible of specialist visit when specialist care is directed by a primary care physician. We believe that primary care physicians serve an important role in directing the overall care of patients and are increasingly being incentivized to do so in a cost-efficient manner.

45 CFR § 156.50 FTE User Fee for the 2017 Benefit Year (pages 75544-45)

When responding in writing to a query from Congress on Sept 23, 2015, Acting CMS Administrator Andy Slavitt stated: “Healthcare.gov is a scalable platform, meaning that the cost to provide eligibility and enrollment functionality for additional states is marginal.” Meaning, adding Oregon to the scalable federal platform had only a marginal cost. So, we question the reasonableness of the proposed fee as it relates to the actual cost of adding states to the platform.

The costs attendant to state-based marketplace utilization of federal services should reflect the number of enrollees required to be serviced rather than an arbitrary percentage of the premium generated by those enrollments. If premiums increase, the user fee percentage will increase. The increase in fee will have no relation to any additional services provided to an SBE-FP. The increase in user fee will be arbitrarily tied to an increase in premium which has no bearing on the cost of the “FFE information technology infrastructure, the consumer call center, and eligibility and enrollment services.” The expense associated with delivery of enrollment and eligibility services is more appropriately enrollment based.

Oregon supports a fixed per enrollee per month platform fee. This offers predictability for both HHS and the state-based marketplaces. Rather than have the user fee be arbitrarily tied to premiums, which could cause the appearance that CMS has a financial interest in higher premiums, have a user fee based on number of enrollees and a predictable flat monthly fee.

The select services provided by CMS lack standard industry deliverables and should be priced accordingly:

The federal eligibility and enrollment system has not demonstrated any real-time or ad hoc state-based reporting capabilities. No service level agreements have been offered, and no information provided as to data security levels or protections.

Lack of flexibility in the federal system has also led to potential consumer harm issues. The inability to suppress incorrect plans in a reasonable time can lead to consumer harm. We cannot determine the value of the federal call center as CMS does not provide the Exchange with any indication of the number of calls received from Oregonians, making it difficult to understand the workload generated by Oregon consumers.

In consideration of the above and recognizing the extensive array of services an SBM must provide at the state level, a fee of one to two percent of premium is more reasonable than three percent. However, if HHS mandates a three percent user fee, Oregon asks that HHS delay implementation of the fee and requests that HHS reduce the user fee to one-half to one percent for the 2017 benefit year. Additionally, we request the option to collect the federal assessment on behalf of the federal government so that our issuers are not burdened with separate fee payments to separate entities.

Because SBE-FPs will differ in the federal services used, we suggest that, instead of the proposed fee structure, HHS unbundle the fee into a number of separate services and allow states to opt out of services not used or allow states to negotiate lower fees for services they rarely use. We further recommend that HHS impose fees based on service-level agreements with performance reporting and payment incentives or penalties.

Finally, because Oregon imposes its own administrative fee as a specified dollar amount times the number of members enrolled through the Marketplace in a month. We suggest that SBMs be allowed to negotiate alternative methodologies for imposing the fee, such as on a per member per month basis.

45 CFR § 156.235 Essential Community Providers (pages 75552-53)

Given the relative scarcity of essential community providers, we agree that issuers should be given credit for multiple essential community providers at a single location. However, we do not see the need to wait until 2018 to implement this change

45 CFR § 156.265 Enrollment Process for Qualified Individuals (page 75553)

We agree with the approach outlined in 156.265(b)(2)(ii) because it benefits consumers and the shopping experience. We believe the same standards should apply for web brokers.

Standards for Qualified Health Plan Issuers on Federally-Facilitated Exchanges and State-Based Exchanges on the Federal Platform (page 75554)

The inability of the FFE to accommodate State customization is a huge disadvantage to using the federal platform. Each state's population has unique needs, including needs for state-specific SEPs. States also have specific regulatory requirements, enforcement procedures, and consumer advocacy tools designed to comply with state regulations. For instance, in Oregon we are considering a premium assistance program for COFA islanders. The program will make insurance more affordable for thousands of Oregonians, but the lack of options for a state-specific SEP would mean that the start of the program could only begin during open enrollment, limiting our ability to get people covered sooner or forcing us to wait an entire year in case it isn't ready soon enough for the next open enrollment period.

If a state elects to use the FFM for only individuals or only for SHOP, issuers should only be required to comply with the operational standards of the FFM for that market, not both.

We have significant concerns about the enforcement provisions proposed in paragraph (c). Oregon law outlines specific review and enforcement authority. We oppose these provisions and believe that HHS should defer enforcement issues to state-based exchanges, including SBE-FPs, and the issuer's state regulator. The Department is concerned that using two sets of enforcement standards will lead to consumer harm and insurer confusion.

45 CFR § 156.810 Enforcement Remedies in Federally-Facilitated Exchanges (pages 75554-55)

We seek to clarify that under 156.810, HHS will defer to SBE-FPs for decertification decisions. SBE-FPs in conjunction with the state's regulatory counterpart is in the best position to make the determination whether the state enforcement action or the issuer's financial condition warrants decertification. Absent such deference, we oppose this proposal.

45 CFR § 156.1256 Other Notices (page 75558)

In general, we agree that issuers should be required to notify consumers under the circumstances discussed in the rule. However, the Department believes state regulators, including the State-Based Marketplace and the Insurance Division, are the appropriate entities to work with insurers to identify plan errors, issue appropriate consumer notices, and develop enforcement actions consistent with state regulation.

Closing Remarks

The Department appreciates the opportunity to provide feedback to HHS and would like to encourage early release of final regulations to allow maximum time for implementation. For further clarification on our comments please contact:

Jeannette Taylor, Senior Health Policy Analyst
Jeannette.N.Johnson@oregon.gov

Thank you,



Patrick Allen, Director
State of Oregon Department of Consumer and Business Services