

October 31, 2011

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

**Re: File Code: CMS–9989–P (Patient Protection and Affordable Care Act;
Establishment of Exchanges and Qualified Health Plans)**

Dear Secretary Sebelius:

Thank you for the opportunity to comment on the department of Health and Human Services requirements relating to the establishment of Exchanges and Qualified Health Plans (QHPs). The Disability Rights Education and Defense Fund (DREDF) is a leading national law and policy center that advances the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development.

State and regional health exchanges will be the forum where expanded health care coverage for Americans will or will not be accomplished. This is a historic opportunity to include the voice, and address the needs, of people with disabilities in healthcare, an arena where all too often we have been viewed as objects rather than subjects of reform.

DREDF applauds the Department of Health and Human Services (HHS) for establishing regulations to guide states and including a broad mandate in the regulation that prohibits discrimination on the basis of disability, as well as race, color, national origin, age, sex, gender identity, and sexual orientation. We continue to feel strongly, however, that the draft Exchange regulations can, and must, be further developed to give states further guidance about what Exchanges and QHPs need do to ensure non-discrimination in practice given the longstanding health disparities experienced by people with disabilities. It cannot be simply “business as usual” in the guise of a new marketplace.

Two recent reports have helped further elaborate the healthcare experiences of people with disabilities. One study out of the University of Kansas analyzed existing data from the national Medical Expenditures Panel Survey (MEPS) to supplement a growing body of literature which shows that people with disabilities experience multiple barriers to participation in health promotion and disease prevention programs. The study found that adults with physical disabilities or cognitive impairments “had significantly higher prevalence rates for 7 chronic diseases than persons with no disabilities. The disability groups were also significantly less likely than the no disability group to receive 3 types

of preventive care.”¹ The authors concluded with a call for public health interventions to ensure that the unique needs of adults with disabilities, and the number of people reporting a disability or functional impairments is rising, can lower the risk of high cost, debilitating conditions that may also have a more severe effect on this population segment.

The HHS Advisory Committee on Minority Health focused even more specifically on the health status of minorities with disabilities to conclude that “[a]side from the public health issues that most racial/ethnic minorities face, minorities with disabilities experience additional disparities in health, prejudice, discrimination, economic barriers, and difficulties accessing care as a result of their disability—in effect, they face a “double burden.”²

In light of these outstanding concerns, it is critical that state Exchanges adhere to the following requirements which address additional concerns in specific subject areas relating to consumer representation, physical and programmatic accessibility in both healthcare delivery and procedural protections, and data collection. We appreciate the Department’s commitment to giving states the opportunity to flexibly meet the needs of their local market, but strongly advocate on behalf of all people with disabilities that the following measures are needed in all states and exchanges to ensure that the members of our community are not left behind when it comes to the benefits of health reform.

Our comments will primarily be following a thematic format, but will also include references to specific regulatory sections where appropriate.

Non-Discrimination

DREDF supports the draft regulation’s incorporation of clear prohibitions against discrimination based on disability, as well as race, color, national origin, age, sex, gender identity, or sexual orientation on the part of States and Exchanges (§ 155.120(c)). We are, however, concerned that the present reference does not clearly indicate that adherence with federal and state non-discrimination law is required from all entities that operate in the exchange, and includes **all** the operations of QHP issuers that choose to participate in the Exchanges. The State and Exchange must ensure that QHPs do not engage in discrimination, and it is our position that QHP issuers are themselves recipients of federal financial assistance under § 1557 of the ACA as a “health program or activity, *any part of which* is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance.” The plain language of § 1557 appears to be contradicted by the directive in § 156.205(e) of the proposed regulation that QHP issuers “must not, *with respect to its QHP*, discriminate.” [Emphases added] The regulatory limitation should be removed to bring the section into line with the intended reach of the ACA. This same analysis regarding the non-discrimination mandate applies to any “federally-facilitated” Exchange, as they are “administered by an

¹ Disability Health J. 2011 Apr 4(2): 59-67. Epub 2010 Jul 14.

² From HHS Advisory Committee on Minority Health, Assuring Health Equity for Minority Persons with Disabilities: A Statement of Principles and Recommendations (July 2011) at 11

Executive Agency” within the meaning of § 1557, and to the issuers of multi-state plans, as defined in § 155.1000(a), since they contract with the federal government to offer a multi-State QHP through the Exchanges.

We further recommend that § 156.205(e) specify that once a QHP issuer chooses to participate in an Exchange, then all of that entity’s programs, activities, and products will be subject to federal and relevant state non-discrimination requirements. This specification is particularly important when the QHP issuer is operating as a health maintenance or other managed care organization, and should encompass the QHP issuer’s administration of, or contractual relations with, hospitals, health clinics, health research institutions, health education programs, public health programs, individual providers, physician groups and similar associations of health care professionals who operate between health insurance programs and individual doctors’ offices, and all other health care delivery and business operations encompassed in coordinated care delivery.

With regard to the non-discrimination provisions of the ACA, we have advocated in prior comments, and will continue to advocate, for implementing regulations that explicitly recognize that the obligations and coverage imposed by § 1557 are independent of, and do not reduce, obviate or alleviate obligations not to discriminate on the basis of any personal characteristic that is imposed by any other current or future law, regulation, executive order, court order or consent decree, including the requirements of state or local laws or applicable private regulatory bodies or organizations. Multi-state plans are already exempt from Exchange certification processes, according to § 155.1010(b), and therefore might be considered exempt from any non-discrimination requirements imbedded in the certification process.³ The proposed exchange regulations already clearly indicate that Multi-State plans must meet a state’s rating requirements even if they are more restrictive than Federal rating requirements under the federal Public Health Services Act, and this should also hold true for Multi-State plans and a state’s non-discrimination laws. Multi-state plans should meet the highest non-discrimination provisions of the states that they choose to operate in.

Finally, DREDF would like to raise a critical due process issue relating to the proposed non-discrimination requirements. There does not appear to be an actual complaint mechanism for encountering discrimination in the Exchange or in QHPs. The regulations should specify that discrimination and civil rights complaints should not simply be entrusted to the Exchange’s internal resolution. The state and/or HHS’ office of civil rights must bear responsibility for monitoring and receiving such complaints and following through on investigation and resolution. It should also be clear, however, that any such administrative compliant procedures have no impact on existing private rights

³ The fact that multi-state plans are exempt from state makes it even more important for Section 1557 regulations to contain the clear statement that they are not reduced, obviated, or alleviated by any other current law or regulation that provides less protection against discrimination than the ACA, including provisions that allow discrimination based on pre-existing conditions.

of action under any federal or state non-discrimination law, and do not serve as an exhaustion requirement.

Consumer Representation: Governance and Consultation

The regulations specify that exchanges will have responsibility for establishing and overseeing the individual applicant process, as well as QHP certification, which hinges upon a determination that making a health plan available is “in the interest of the qualified individuals and qualified employers.” § 155.110(c)(3) also indicates that the State must ensure that the Exchange’s governing board structure “[r]epresents consumer interests” by not having a majority of voting representatives with a conflict of interest.

DREDF supports the above references that tie the Exchange functions to the well-being and interests of consumers, but finds the bare requirement that a majority of voting representatives not have a conflict of interest insufficient to structurally safeguard the stated goals. Most Board members may be free of a conflict of interest, and yet have little or no experience with the concerns, access issues, and health disparities encountered by people with disabilities and other specific underserved consumer groups. At least one consumer representative should be mandated at the governance level, and DREDF further believes that the standards should be to disallow **any** voting representative with a conflict of interest. We understand and accept that an Exchange board can benefit from the expertise and knowledge of health insurance issuers, agents or brokers and representatives of others licensed to sell health insurance. However, those interests are included as mandatory consulting stakeholders in § 155.130, and an Exchange board also has the option to establish an advisory committee partly or wholly composed of such individuals. The federal regulations on this issue should strongly encourage states to establish Exchange boards that not only serve the public and consumers with undivided good faith, but are also wholly free of even the appearance of conflict. In this spirit, there is no reason to enable up to 49% of the voting representatives of an Exchange board to serve with a conflict of interest.

As mentioned immediately above, § 155.130(a) establishes certain stakeholder groups with whom the Exchange must regularly consult. Again, DREDF supports this idea, but finds it to be quite possibly an instance of “too little, too late.” Exchanges ideally should be consulting healthcare consumers and advocacy groups, including people with disabilities and consumer advocates, *before* enrollment actually begins. The recommendation in the preamble that people with disabilities be included as “educated consumers” and disability advocates be included as advocates for “hard to reach populations” makes sense as a requirement within the provision itself, and should be expanded to include consultation with consumers and advocates that reflect a diverse range of functional impairments. These additional requirements would help ensure that Exchanges develop and function in a truly accessible manner that complies with the non-discrimination requirements of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act (Section 504), and relevant state non-discrimination laws. Moreover, the close involvement of people with various disabilities in the quality

improvement function of Exchanges enumerated in § 155.200(f) will help Exchanges to continually improve their communications and interactions with a critical and growing population demographic.

Marketing, Outreach and Consumer Assistance

We must stress the need for communication accessibility to be infused throughout the marketing and outreach process. The consumer assistance tools and programs specified in § 155.205 will only serve their function for applicants and enrollees with disabilities to the degree that they are fully accessible. Call and drop-in centers must be staffed by representatives who are trained to provide reasonable accommodations, have disability and linguistic cultural competence, and understand how to accept TTY or relay service calls from Deaf persons. Internet websites must meet the technical requirements of Section 508 of the Rehabilitation Act. Important online tools such as the Exchange Calculator and consumer assistance referrals must be accessible and independently useable as much as possible by people with disabilities.

The central role of the navigator program merits special attention. We support the requirement in § 155.210(d)(5) that Navigators must provide culturally and linguistically appropriate information and “ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.” We strongly encourage the Department to further elaborate on what accessibility and usability will require in practical terms. For example, Navigators must be able to use clear, simple language to explain plan benefits and services where needed as an accommodation to ensure that individuals with cognitive disabilities have an equal opportunity to benefit from participation in the Exchange. The categories of entities identified in § 155.210(b)(2) as ones that must be included in any Exchange to receive a federal Navigator grant bring important and diverse expertise, but very few will have any actual experience meeting the accessibility and LEP needs of applicants with diverse, and often overlapping, communication, linguistic, and cultural needs. Some may “be capable” of carrying out accessibility requirements in the sense of having web support, providing multiple points of contact with the public, and having a genuine desire to be helpful. It does not necessarily follow that Navigators will proactively give notice of, consistently offer, and successfully provide, accessible and equally effective communications, web tools, and information that meet the accessibility requirements of the ADA and Section 504. Federal leadership in providing standards and guidance will be critical in this area so that, for example, Exchange and Navigator representatives will not make such common mistakes as assume that Deaf and LEP individuals are responsible for bringing their own translators, or advise a person with mobility impairments that his health plan **can** require him to enter a hospital for treatments that are available at outpatient clinics to plan members without mobility impairments..

With regard to the list of organizational categories set out in § 155.210(b)(2), two of which are required to be included by an Exchange for receipt of a navigator grant, we understand the need for both breadth in the list and flexibility the need to have flexibility

in the appointment of navigators. Experienced community non-profits can be rare in rural areas, in particular, and there are areas in the U.S. where a local government office, chamber of commerce, or a fishing, ranching, or farming organization truly is “the place where everybody goes for information.” We suggest, however, that the list should be prioritized to reflect the fact that community and consumer-focused non-profit groups are **best** suited to fulfill the consumer protection role of Navigators. Such a prioritization would honor an Exchange’s need for flexibility depending on the availability of different entities in different areas, but also ensure that a professional association of practicing licensed agents and brokers will not be chosen over a well-connected non-profit community-based organization in any urban area.

The final rules should set the following additional requirements concerning Navigators:

- Prioritized awarding of navigator grants to community and consumer non-profit groups who already have established links with underinsured and/or underserved consumers, are least likely to have conflicts of interest, and exemplify the consumer outreach role of Navigators;
- Sufficient funding and technical support to enable all navigators to provide effective communication and cultural and linguistic accessibility across the breadth of eligibility, enrollment, and program specification and public education activities;
- Input and product testing from consumers with various disabilities, especially communication-related disabilities, on reasonable accommodations and policy modifications designed to ensure that Navigator tools and materials are accessible;
- Ongoing training with periodic refreshment on providing accessible and culturally and linguistically accessible outreach and education materials and activities and applicable privacy and consumer protection laws;
- State oversight and coordination of the outreach and consumer assistance roles that existing state agencies, the Exchange, and Navigators will play, to achieve both unity of purpose and ensure against gaps in consumer outreach to consumers with disabilities and other uninsured and underinsured groups.

Application and Grievance Procedures

DREDF supports §155.405(c)(2), which appropriately establish that applications may be submitted via the internet, by telephone, by mail, and in person. The range of options increases the opportunity for individuals with various disabilities to independently negotiate the application process, and therefore maintain greater control over confidential personal information. We think that is necessary to further clarify that disability accessibility must be developed and maintained for each of these modes of application. For example, the call center must accept TTY and relay service calls, and in-person representatives must be trained to offer the reasonable assistance needed by a person with a disability, regardless of the fact that the internet portal is accessible and there is a mail-in option.

One important issue that is not addressed in the application procedures, however, concerns the many detailed enrollment time frames. The regulations should require that exchanges make reasonable modifications to the rules concerning initial, annual, and special enrollment periods when necessary to afford equal opportunity to people with disabilities. For example, an individual may require a longer enrollment period where her disability resulted in a temporary hospitalization, or where a triggering event also results in an individual with visual impairments temporarily or permanently losing his spouse and trusted reader, interfering with their ability to complete the process of switching to a new QHP.

The wording of § 155.430(c)(3), which requires issuers of QHPs to provide reasonable accommodations to individuals with certain disabilities before terminating coverage, is an excellent beginning. However, we believe this provision should not be limited to those with “mental or cognitive conditions, including mental and substance use disorders, Alzheimer’s disease, and developmental disabilities,” as this draws unnecessary distinctions among people with disabilities when health coverage is clearly vital to the entire population’s health maintenance in the community, and fails to recognize how many complex health conditions and functional impairments interact to place extraordinary health management burdens on the individual consumer. We strongly advise:

- § 155.430(c)(3) be broadened to include all individuals with disabilities to ensure that issuers of QHPs cannot draw the negative inference that they need only provide reasonable accommodations to people with **certain** conditions and disabilities before terminating coverage;
- Inclusion of a provision along the same lines of a broader § 155.430(c)(3) that will require exchanges to establish reasonable accommodations and policy modifications to their enrollment periods for people with disabilities, including open enrollment periods, special enrollment periods, and coverage termination.

Accessibility Requirements, Including Provider Network Requirements

The few specific references to accessibility and non-discrimination for people with disabilities need strengthening and expansion. Applicable non-discrimination laws, including Section 504 of the Rehabilitation Act of 1973 (Section 504) and the Americans with Disabilities Act (ADA) have always applied to the field of healthcare. Section 1557 of the ACA explicitly incorporates the non-discrimination requirements of Section 504 that require program access and equally effective care for people with disabilities in any health program or activity that is federally conducted, receives federal financial assistance, or is established under the ACA. Nonetheless, the longstanding and increasingly documented inaccessibility of healthcare services experienced by people with various disabilities calls for a more uniform and detailed explication of what Exchanges and QHPs must do to ensure physically and programmatically accessible

service delivery,⁴ given the critical role that both entities will play in healthcare reform and expanding access to health coverage. Broadly speaking, the provision of physically and programmatically accessible healthcare will require federal regulation in the following three areas:

1. Outreach, marketing, and enrollment materials must be provided in alternative formats and effectively communicated to people with communication, print, and mobility disabilities, whatever the medium of communication. For Exchange internet websites, this means procuring, maintaining, and using information and information technology, whether directly or through the use of state or federal funds by other entities, that complies with the accessibility requirements of Section 508 of the Rehabilitation Act of 1973, as amended, and regulations implementing that act. For many individuals with disabilities of low income who do not have the means to acquire or use accessible computer technology, effective communication must be extended through TTY phones and/or the use of telephone relay services, trained in-person interactions, and the provision of such alternate formats as Braille, large font print, CD, audio-recordings, or electronic mail.
2. The QHP provider network adequacy standards referred to § 155.1050 must include clear requirements for physical and programmatic accessibility and sufficient depth and breadth of specialist care. The “sufficient choice” mandated by § 155.1050 is only illusory if QHPs cannot guarantee such basic accessibility measures as: (i) enrollees with disabilities will be able to approach, enter, and use the facilities (including facility parking lots, waiting rooms, examination and treatment rooms, and restrooms) as conveniently as everyone else; (ii) adjustable screening and diagnostic equipment and lifts will be available; (iii) communication accommodations such as ASL interpretation and alternative formats will be provided; (iv) modified appointment times will be given when needed by, for example, people with developmental disabilities; and (v) culturally competent service from providers and office staff.
3. Periodic ongoing monitoring and enforcement by CMS, Exchanges, and within QHPs to ensure compliance with the communication and provider network standards referred to above, including consumer survey and quality assurance mechanisms that will support quality assurance provisions.

The first area has already discussed to some extent, and will primarily affect §§ 155.200, 155.205, 155.210, 155.230, 155.405, and 155.410, as well as SHOP requirements relating to applications and notification procedures. DREDF can provide

⁴ Programmatic accessibility refers to the reasonable accommodations and policy modifications that may be required by a person with a disability to receive an equally effective service, and include such accommodations as providing assistance with undressing, transfers to exam tables, or filling out printed forms, or offering modified appointment times.

three further examples to illustrate why the federal Exchange regulations should provide more detailed standards concerning website access.

First, § 155.205 explicitly requires the Exchange to maintain an up-to-date Internet website that “is accessible to people with disabilities,” but that requirement appears to apply only to the Exchange’s website function, while other Exchange functions like the establishment of a Call Center, an electronic Exchange calculator, and outreach and education services, do not appear to have any kind of explicit accessibility requirement. Second, § 155.405 states that Exchanges must “provide the tools to allow for an applicant to file an application . . . [v]ia an Internet portal.” An applicant with visual disabilities and computer access would be perfectly capable of independently filing such an application, but could not do so unless the online application was at least fillable and submittable online. The stark directive to “provide the tools” would not necessarily ensure that an Exchange will engage in the kind of initial investigation and investment, and ongoing maintenance, required to ensure that such forms are provided and maintained on the web. Finally, no current provision in the regulations seems to place a strong notice requirement on Exchanges or QHPs concerning the availability of communication and other reasonable accommodations. A public notice requirement, designed to include people with various communication disabilities as well as LEP individuals, is critical to ensuring effective communication. Individuals will not ask for needed accommodations if they do not know they exist or that they have a right to them.

As a final note on this topic, DREDF has observed that effective communication is very rarely achieved through machine and online translation tools for captioning the spoken word. The results are unreliable even in a pure entertainment context, much less for translation of specialized insurance and medical terminology. The regulation should clarify that machine or online translation “tools” which purport to translate spoken words, for example in an instructional video, into captioning for individuals with hearing impairments or another language for LEP individuals, are prohibited unless they can meet a very high accuracy and reliability threshold. This would help to weed out unverified and usually inaccurate tools, and leave the door open for technological improvements if such should occur.

The need for detailed physical and programmatic accessibility standards in general is uniformly shared by people with disabilities, regardless of the state in which they live or the exchange for which they are eligible. It is extremely difficult to think of local conditions that would justify an exchange’s failure to specify, monitor, and enforce accessibility standards for itself and for QHPs, but it is easy to imagine budget-focused states simply overlooking the need and leaving people with disabilities to fend for themselves when it comes to navigating inaccessible exchange and QHP enrollment and appeal procedures and provider networks. A regulatory patchwork among states would also potentially have a negative impact and incentive on multi-state plans that could choose to avoid offering products in states that imbed better consumer protections and accessibility requirements. On the other hand, a multi-state plan that offered a uniform product that met all QHP requirements for the states in which they operated (§ 155.1000(a), including those states with stricter accessibility requirements,

would be unnecessarily disadvantaged by having to compete with individual state plans in states that have few accessibility requirements. In a time when overall American poverty levels are rising and state governments are constantly looking for ways to cut costs, the burden for enforcing Federal and state physical and programmatic accessibility obligations should not fall on individual applicants with disabilities seeking coverage through the exchange; it should be undertaken through the cooperative efforts of all levels of governments, Exchanges, and QHPs. The development and enforcement of uniform federal exchange regulations clearly establishing physical and programmatic accessibility standards are the best way to achieve accessible service delivery at the insurer and provider level.

§ 155.1050 is really the only provision that creates a requirement pertaining to QHP provider networks, and it merely states that the Exchange must ensure that each network “offers a sufficient choice of providers for enrollees.” This could be interpreted to simply mean that QHPs must have sufficient numbers of primary care providers and specialist provider categories to service a population with average health needs. This would utterly fail to recognize that people with disabilities have no real “choice” of providers if many of the appropriate providers in one’s city have waiting lists; if 95% of providers fail to have accessible adjustable equipment; if specialist after specialist fails to provide needed communication or other programmatic accommodations such as ASL interpretation or longer appointment times for those with cognitive disabilities; or if the provider network overall fails to have sufficient breadth and depth of specialist knowledge and coordination experience to serve the reasonable medical and community service needs of people with various disabilities, including such critical ancillary service needs as personalized fitting for durable medical equipment items such as wheelchairs, orthotics, and prosthetics.

Exchange operations will not genuinely include or effectively serve the needs of people with disabilities unless:

- the QHP certification standards of § 155.1000(c) require Exchanges to determine that making a health plan available “is in the interest of qualified individuals and qualified employers, including individuals with disabilities”;
- the minimum certification standards in subpart C of part 156 establish clear effective communication standards for all QHP interactions with people with disabilities, including marketing efforts, internet applications and individual member notices;
- clear physical and programmatic standards are included in the minimum network adequacy standards of § 156.230 that apply across the entire provider network, including essential community providers;
- guidance and technical assistance is given to QHPs and providers concerning the need to ensure that all services are provided to people with disabilities in the most integrated community setting;
- § 156.275 includes disability-specific measures among the factors according to which QHP issuers will receive and maintain accreditation, and QHP issuers and

their accrediting entities are required to maintain consumer transparency in their accreditation surveys and related appropriate information, such as corrective action plans and finding summaries.

Survey and Data Collection

DREDF advocates for the inclusion of disability-specific data measures to be included whenever the proposed regulation imposes data obligations on QHP issuers, Exchanges, or the State. Without such measures, HHS, disability advocates, and the disability community will be unable to discern, analyze, and ultimately correct areas where people with disabilities are not being effectively served through QHPs.

In addition, we would like to point out that § 4302 of the ACA, calls for the collection of data on disability status for applicants, recipients, or participants by any federally conducted or supported health care or public health program, activity or survey, **and** also requires the collection of additional information related to specific, known barriers to healthcare that affect individuals with disabilities and that contribute to the health and health care disparities they experience. Section 4302 sets forth the following specific data collection standards:

“[S]urvey health care providers and establish other procedures in order to assess access to care and treatment for individuals with disabilities and to identify—

- “(i) locations where individuals with disabilities access primary, acute (including intensive), and long- term care;
- “(ii) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the minimum technical criteria
- “(iii) the number of employees of health care providers trained in disability and patient care of individuals with disabilities.”

While it is true that the HHS’s Notice of Proposed Rulemaking related to implementation of the Section 4302 requirements did not address the above provisions, DREDF understands that HHS representatives are identifying relevant information and mechanisms by which the required data could be collected. DREDF has also made specific suggestions regarding methods to identify and collect such information, and direct you to the letter submitted to Dr. Garth Graham, Deputy Assistant Secretary for Minority Health, David Meyers at AHRQ and Marsha D. Lillie-Blanton at CMS/CMCS on April 28, 2011 by the Leadership Conference on Civil Rights (LCCR). We also direct you to a similar letter submitted by the National Council on Disability (NCD). QHP provider networks provide an existing infrastructure that could be used to identify the accessibility of provider offices and outpatient facilities, including long-term care services, and the level of disability awareness and training within those offices and facilities. By establishing physical and programmatic provider network criteria and data collection requirements for QHP issuers, these regulations could help prepare network providers to understand the underlying need for this critical data, as well as collect the

data in a consistent, accurate, and efficient manner.

Thank you again for this opportunity to comment on the Departments' Proposed Regulation on the establishment of Exchange and related standards.

Yours Truly,

A handwritten signature in blue ink that reads "Susan R. Henderson" followed by a horizontal line.

Susan Henderson,
Executive Director