ACAP
Association for Community Affiliated Plans

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October 31, 2011

Dr. Donald M. Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244
File code: CMS–9974–P

Submitted electronically via: *http://www.regulations.gov*

Dear Dr. Berwick:

The Association for Community Affiliated Plans (ACAP) very much appreciates this opportunity to provide comments to the Center for Consumer Information and Insurance Oversight (CCIIO) in response to the proposed rule called *Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers* (CMS-9974-P; 76 Fed. Reg. 51202 (Aug. 17, 2011)) codifying portions of the Patient Protection and Affordable Care Act, enacted on March 23, 2010.[1]

ACAP is an association of 59 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 28 states.[2] Our member plans provide coverage to 9 million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dual eligibles. Nationally, ACAP plans serve approximately one-third of all Medicaid managed care enrollees. Safety Net Health Plans currently are developing plans to serve those individuals that will gain new coverage due to insurance expansions enacted by the Affordable Care Act; such plans must be viewed as full partners in meeting the coverage needs of our nation's low-income health care consumers – whether they are eligible for Medicaid, CHIP, coverage in health state-based health insurance Exchanges, or other health care programs.

ACAP is limiting our comments primarily to issues that are of particular importance to Safety Net Health Plans as they strive to support the implementation of the Affordable Care Act. We also have attached, incorporate and (where, we believe, particularly relevant to our comments herein) reiterate the comments we submitted to the Department of Health and Human Services (HHS) today regarding *Medicaid Eligibility Changes under the Affordable Care Act of 2010*, CMS-2349-P; 76 Fed. Reg. 51148 (Aug. 17, 2011). We have also attached comments submitted today to the Department of

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[1] The Patient Protection and Affordable Care Act (P.L. 111-148) and the Healthcare and Education Reconciliation Act (P.L. 111-152) together are referred to in this letter as the Affordable Care Act.

[2] ACAP represents Safety Net Health Plans that are exempt from federal income tax, or that are owned by an entity or entities exempt from federal income tax, and in which no less than 75 percent of the enrolled population receives benefits under a Federal health care program as defined in section 1128B(f)(1) (42 USC 1320a-7b(f)(1)) or a health care plan or program which is funded, in whole or in part, by a State or locality (other than a program for government employees).

Treasury, Internal Revenue Service regarding *Health Insurance Premium Tax Credit*, REG-131491-10; 76 Fed. Reg. 50931 (Aug. 17, 2011).

A summary of ACAP's comments follows here:

1. ACAP strongly supports the inclusion of all coverage options, including the Basic Health Program, for lower-income health care consumers in the definition of *insurance affordability programs*, and in efforts to coordinate and streamline eligibility, enrollment and coverage for all people.
2. ACAP urges CMS to consider allowing states to implement twelve-month continuous eligibility for adults in Medicaid without requesting a waiver.
3. ACAP recommends that CMS adopt regulations which would allow individuals determined ineligible for Medicaid, but eligible for a premium subsidy, to retain membership in their Medicaid health plan on an opt-out basis, and that HHS allow Exchanges to certify as licensed those Medicaid and CHIP health plans with enrollees who move into the Exchange and which cover families with split eligibility for the purpose of continuing to cover those individuals and families only.
4. ACAP strongly supports allowing the Exchange to administer premiums, and encourages HHS to promote this practice among state Exchanges.
5. ACAP recommends that CMS develop contingency plans, standards and/or phase-in approaches for the purpose of coordinating eligibility and enrollment policies in the Exchange, Medicaid, CHIP and BHP to reflect the environment which is likely to be in effect as of January 1, 2014.

The proposed Exchange eligibility rule intends to:

- Implement certain functions of the new Affordable Insurance Exchanges consistent with title I of the Patient Protection and Affordable Care Act.
- Provide guidance to states as they build Exchanges that will "provide competitive marketplaces for individuals and small employers to directly compare available private health private health insurance options on the basis of price, quality, and other factors."
- Propose "specific standards for the Exchange eligibility process… ."

We are strongly supportive of the elements of the new regulations that further the goal of ensuring that all Americans can easily enroll in and retain health coverage. The implementation of a simple, streamlined eligibility and enrollment process that minimizes administrative burdens on both applicants and reviewers for all coverage options and provides appropriate assistance to applicants as they work to understand their options, is clearly integral to meeting this goal. We applaud the Department of Health and Human Services on its efforts.

We respectfully urge you to consider the following expanded comments that will help to ensure that low-income health care consumers are well-served by the Exchanges and qualified health plans.

Subpart D – Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

Section 155.399. Definitions and General Standards for Eligibility Determinations.

This subpart provides definitions for a number of terms that have not previously been defined by the Department, including *insurance affordability programs*, which are defined as "advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP and the Basic Health Program, as applicable."

ACAP supports the various options for coverage provided by the Affordable Care Act to lower-income health care consumers, including federal premium tax credits and cost-sharing reductions, Medicaid, CHIP and the Basic Health Program. We feel as though all states must consider a number of factors in determining how best to provide a mix of coverage programs to provide to consumers. In particular, because of the program's propensity to lower costs for low-income individuals, we feel strongly that the Basic Health Program should be included among those options. By including all of these options, including the Basic Health Program, in the definition of *insurance affordability programs*, and by describing in the preamble of the proposed rule the Department's interpretation of the Act as leading to the establishment of "a system of streamlined and coordinated eligibility and enrollment" for all programs, the Department indicates to states and other stakeholders its commitment to the goal of "no wrong door" eligibility.

> **ACAP strongly supports the inclusion of all coverage options, including the Basic Health Program, for lower-income health care consumers in the definition of *insurance affordability programs*, and in efforts to coordinate and streamline eligibility, enrollment and coverage for all people.**

Section 155.330 Eligibility redetermination during a benefit year

This section requires the Exchange to redetermine the eligibility of an enrollee in a qualified health plan through the Exchange during the benefit year if it receives and verifies information reported by an enrollee or identifies updated information through data matching arrangements. We recognize that mid-year redeterminations of eligibility will reduce the chance that low-income individuals will receive coverage in the wrong program or receive incorrect premium tax credits or cost-sharing reductions. However, ACAP harbors concerns regarding the frequency with which lower-income Exchange enrollees can be expected to experience changes in income that will impact their eligibility, and feels strongly that the Exchange should be allowed to employ a variety of policies to coordinate coverage for people with changing eligibility.

"Churn" has long been recognized as a substantial problem in Medicaid and CHIP. It is well established that gaps in coverage have a negative impact on quality and continuity of care and result

in increased hospitalizations and costly emergency department visits. [3] Conversely, retention of coverage permits Medicaid enrollees to establish long term relationships with their primary care providers, but frequent loss of coverage interrupts these relationships. Studies also show that the longer an individual remains enrolled in Medicaid, the lower their average monthly medical costs.[4]

A report published earlier this year demonstrates that when the Affordable Care Act is implemented, 40 percent of those people found eligible initially for Medicaid will experience an income change that will disrupt their eligibility for that program. After one year, 38 percent will no longer be Medicaid-eligible, and an additional 16 percent will have lost and regained eligibility. Among low-income adults initially found eligible for the Exchange**,** 30 percent of adults will experience disruption in Exchange eligibility within six months. After one year, 24 percent will no longer be eligible, and an additional 19 percent will have lost and regained eligibility.[5] This may result in a shift between plans and provider networks, with inevitable disruptions in continuity of care. Insurance coverage disruptions have been shown to have adverse effects on access and administrative costs, and even if there is no gap in coverage, problems can arise simply from a change in plans or providers.[6]

Whereas churn currently causes instability of coverage in the Medicaid and CHIP programs, when the Exchange is operational, income volatility among the newly-covered lower-income Exchange population will cause instability within the new marketplace as well, burdening the Exchange eligibility and enrollment process and those commercial health plans serving as qualified health plans.

> **ACAP feels strongly that providing continuous coverage in Medicaid will provide stability to the Exchange as well. For these reasons, we urge CMS to allow states to implement twelve-month continuous eligibility for adults in Medicaid without requesting a waiver.** Other than Section 1137 of the Social Security Act, which establishes the Income and Eligibility Verification System (IEVS) but which does not mandate that this information be used with any particular frequency, we are not aware of any other provisions of the Act requiring states to reassess eligibility during the benefit period or more often than twelve months. Furthermore, we believe that a regulatory change to permit states to provide for twelve-month continuous eligibility is within the Secretary's general rule-making

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[3] Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, CMS 2349-P, Preliminary Regulatory Impact Analysis, August 12, 2011 (p.5) available at http://www.cms.gov/MedicaidEligibility/downloads/CMS-2349-P-PreliminaryRegulatoryImpactAnalysis.pdf

[4] Ku L., MacTaggart, P., Pervez F., Rosenbaum S., Improving Medicaid's Continuity of Coverage and Quality of Care. George Washington University Department of Health Policy. July 2009. Prepared for Association for Community Affiliated Plans.

[5] Sommers B. Rosenbaum S., Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges. Health Affairs 30, No. 2 (2011) ("Sommers and Rosenbaum").

[6] Sommers and Rosenbaum. Op cit

authority under Section 1102 of the Act, and consistent with Section 1132 which gives the Secretary the authority to issue "such other requirements as…appropriate" to meet the requirements of Title 1 of the Affordable Care Act . The administrative burden of conducting eligibility determinations could be substantially reduced if states could provide for twelve-month continuous eligibility, thereby promoting efficiency and streamlining.

Furthermore, with a particular interest in the coverage needs of low-income individuals who can be anticipated to experience income changes that alter their eligibility between Medicaid and the Exchange as well as families that have members who are eligible for different programs, as noted earlier in this letter, **ACAP recommends that CMS adopt regulations which would allow individuals determined ineligible for Medicaid, but eligible for a premium subsidy, to retain membership in their Medicaid health plan on an opt-out basis. ACAP recommends that HHS allow Exchanges to certify as licensed those Medicaid and CHIP health plans with enrollees who move into the Exchange and which cover families with split eligibility for the purpose of continuing to cover those individuals and families only.** Individuals and families could be offered an "opt-out" if they choose to select a different plan in the Exchange rather than remain with their Medicaid or CHIP plan. If the plan wishes to seek certification as a qualified health plan to serve "all-comers" in the Exchange, the plan can do so by meeting the requirements of that Exchange.

Section 155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions

This section requires the Exchange to make a number of notifications when it determines that an applicant is eligible for advance payments of the premium tax credit or cost-sharing reductions or that an enrollee's eligibility has changed. For example, the Exchange is required to "transmit information necessary to enable the issuer to implement, discontinue the implementation, or modify the level of an individual's advance payments of the premium tax credit or cost-sharing reductions, as applicable."

Medicaid-focused health plans that have not sold insurance in the individual or group markets often do not have experience in collecting premiums from policy holders, and therefore would have to quickly build the capacity to do so if an Exchange were to require qualified health plans to administer the premium function. The draft regulation cited above, along with the data regarding eligibility churn for low-income Exchange enrollees mentioned previously in this letter, suggests that the premium collection function will be tremendously complicated for qualified health plans, requiring HHS, the Exchange, and plans to track varying individual premium payments and premium tax credits throughout the year. ACAP therefore wishes to reiterate a comment submitted to HHS in our letter regarding *Establishment of Exchanges and Qualified Health Plans* (CMS-9989-P, 76 Fed. Reg. 41866 (July 15, 2011)):

Because ACAP strives to reduce barriers for participation by Medicaid health plans in the Exchange for the purpose of ensuring that low-income health care consumers are well-served, and because many Medicaid health plans may not currently have the capacity to collect premiums, **ACAP strongly supports allowing the Exchange to administer premiums, and encourages HHS to promote this practice among state Exchanges.**

ACAP recommends that the federal Exchange also administer premiums.

Section 155.345 Coordination with Medicaid, CHIP, the Basic Health Program and the Pre-existing Condition Insurance Program

This section requires the Exchange to:

- Enter into agreements with Medicaid or CHIP agencies.
- Conduct basic screening for an applicant requesting an eligibility determination for insurance affordability programs to determine if the applicant is potentially eligible for Medicaid on a basis not otherwise considered in the subpart, including disability.
- Promptly submit all eligibility information already gathered to the Medicaid agency.
- Provide advance premium tax credits and cost-sharing reductions if the individual is eligible for them until individual is enrolled in the other program.
- Provide an opportunity for an applicant to request a full determination of eligibility for Medicaid based on eligibility criteria not otherwise described in this subpart for those individuals requesting additional screening.

In addition, this section requires the Exchange, in consultation with Medicaid, CHIP, and the Basic Health Program, to establish procedures to ensure that an eligibility determination for the Exchange, premium tax credits, and cost-sharing reductions is conducted if an application is submitted directly to an agency administering Medicaid, CHIP or the Basic Health Program and the applicant is not eligible for these programs. Further, the section prohibits any duplication of eligibility findings and verification, and requires that eligibility determination processes must be the same across agencies.

ACAP is very supportive of this guidance on the rules for coordination between Medicaid, CHIP, the Exchange and other insurance affordability programs. Once these systems are in place, in concert with the electronic verification processes that are also expected to be in operation, we would expect a substantial diminution in the administrative burden on all parties – applicants, states, CMS, health plans, Exchanges – involved with eligibility determination processes. We support the requirements that Medicaid agencies and Exchanges establish procedures to ensure that applicant information is promptly transferred at appropriate times, that duplicative data requests and verification procedures are avoided, and that Medicaid agencies be required to accept eligibility determinations made by an Exchange without additional review.

As we noted in our comments with respect to *Medicaid Eligibility Changes under the Affordable Care Act of 2010*, CMS-2349-P; 76 Fed. Reg. 51148 (Aug. 17, 2011), however, we are concerned that not all states will be able to implement the required system changes to enable them to meet the intent of the regulations in this section. **As such, we recommend that CMS consider developing contingency plans, standards and/or phase-in approaches to reflect the environment which is likely to be in effect as of January 1, 2014.**

Conclusion

Once again, ACAP would like to commend CMS for its efforts to develop regulations to further the goal of ensuring that all Americans can easily enroll in and retain health coverage. We appreciate your consideration of our comments regarding *Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers*. ACAP is prepared to assist the agency with additional information as needed. If you have any additional questions please do not hesitate to contact Jennifer Babcock at (202) 204-7518 or jbabcock@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer