ACAP
Association for Community Affiliated Plans

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May 11, 2012

Marilynn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244
File code: CMS–9989-F

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

Dear Ms. Tavenner:

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 *Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers* (CMS-9989-F, Federal Register Vol. 77, No 59 (March 27, 2012)) of the Patient Protection and Affordable Care Act, enacted March 23, 2010.[1]

ACAP is an association of 59 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 26 states.[2] Our member plans provide coverage to approximately 9 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible people. Nationally, ACAP plans serve roughly 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; we thank the Centers for Medicare and Medicaid Services (CMS) for viewing these plans 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 respectfully urge you to consider the following comments that will help to ensure that low-income health care consumers are well-served by the Exchanges and qualified health plans (QHPs). We also have attached, incorporate and (where, we believe, particularly relevant to our comments herein) reiterate the comments we submitted to CMS earlier this week regarding *Medicaid Program;*

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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).

Eligibility Changes under the Affordable Care Act of 2010, CMS-2349-F; Interim Final Rules (March 23, 2012)of the Patient Protection and Affordable Care Act, enacted March 23, 2010).

A summary of our comments follows here:

1. Regarding the ability of a state to permit agents and brokers to assist qualified individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for **QHPs**, **ACAP urges CMS to consider a series of standards and practices for agents and brokers that will ensure an even playing field for all**. (Section 155.220(a)(3))
2. Regarding eligibility determinations for Medicaid, CHIP, Basic Health Program (BHP) and the Exchange, **ACAP strongly encourages CMS to reaffirm its commitment to seamless, fully-integrated eligibility systems that provide all health care consumers with "no wrong door" eligibility and enrollment services**. **ACAP also recommends that states be permitted to establish the "screen and refer" process for three years only.** Furthermore, in the event that CMS decides to retain the bifurcated eligibility process currently outlined in the interim final regulation, or allows it only on an interim basis as we have recommended, **ACAP recommends that CMS require states to demonstrate the ability to effectively manage such a situation**. (Section 155.302)
3. Regarding eligibility standards for cost-sharing reductions, **ACAP encourages CMS to make enrollment in the cost-sharing reduction program seamless for all households – even those covered with other households under a single policy – and ensure that all households obtain the full amount of cost-sharing benefits for which they are eligible. ACAP further asks that the Exchange notify households when they do not receive the full amount of cost-sharing reduction for which they are eligible**. (Section 155.305(g))
4. Regarding timeliness standards for Exchange eligibility determinations, **ACAP urges CMS to move toward real-time eligibility determinations for the vast majority of applicants within three years and recommends that CMS describe specific maximum processing timeframes for states on an interim basis, until fully-integrated systems are achieved in 2017.** (Section 155.310(e))
5. Regarding timeliness standards for the transmission of information for the administration of advance payments of the premium tax credit and cost-sharing reductions, **ACAP urges CMS to adopt and require a clear standard for timeliness for the transmission of eligibility information related to premium tax credits. ACAP further asks CMS to require these transfers to occur in real-time and to set a clear timetable in the final rule for achieving real-time determinations of eligibility for premium tax credits and cost-sharing reductions.** (Section 155.340(d))
6. Regarding coordination among Medicaid, CHIP, BHP, PCIP and the Exchange, **ACAP again strongly encourages CMS to reaffirm its commitment to seamless, fully-integrated eligibility systems that provide all health care consumers with "no wrong door" eligibility and enrollment services**. **ACAP also recommends that, if a state elects (for however long permitted by regulations) to have its Exchange merely conduct a preliminary "assessment" of potential Medicaid eligibility and then relinquish the final eligibility determination to the Medicaid agency, CMS should encourage or require the Exchange to determine a child or pregnant woman to be presumptively eligible for coverage in Medicaid and/or CHIP.** (Section 155.345)

II. Provisions of the Interim Final Regulation

Part 155, Subpart C – General Functions of an Exchange

Section 155.220 – Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs

In this section, CMS codifies various functions the Exchange must perform, including providing permission to agents and brokers to assist qualified individuals, qualified employers, or qualified employees to enroll in QHPs (section 155.220).

ACAP recognizes the value of brokers and agents in directing consumers to purchase health coverage, and is aware that policies impacting the use of brokers and agents differ from state to state and market to market. To expand upon their missions of working with low-income enrollees of Medicaid and CHIP, ACAP Safety Net Health Plans anticipate serving a relatively low-income and high-needs population in the Exchange. These plans expect their enrollees to benefit from the community-based education and outreach activities provided by community-based organizations, including those serving the Navigator program. While some ACAP plans intend to use the services of brokers and agents when the Exchanges are operational, it is uncertain whether all will.

For these reasons, and to maintain an even playing field for all QHPs, ACAP urges CMS to take the following approaches concerning the involvement of agents and brokers in helping consumers apply for premium tax credits, as well as coverage in a QHP and cost-sharing reductions. All Exchanges should:

- **Require that agents and brokers be paid the same** amounts inside and outside of Exchange and regardless of which plan a consumer chooses.
- **Require that payments to brokers and agents be transparent.** If information related to brokers and agents is included on an Exchange's website, the website should also display information on broker and agent fees.
- **Implement a system that pays brokers and agents a flat fee.** Although brokers and agents currently are paid a percentage of premiums, ACAP believes that incentives to steer patients to expensive plans will be mitigated if brokers and agents be paid a flat fee.
- **Provide QHPs with a choice** regarding:
    - Whether to use brokers and agents.
    - Which brokers and agents to use.
- **Allow brokers and agents to charge QHPs directly *only* when a broker or agent sells that particular QHP to a consumer.** If no broker or agent sells the QHP (i.e., the plan is purchased directly by the consumer), the plan should not be charged a fee for that agent or broker.
- **Exclude broker and agent fees** from the Exchange's overhead.
- **Require brokers or agents to meet high knowledge standards regarding insurance affordability programs.** ACAP believes that all brokers and agents should be required to meet high standards in terms of their knowledge of complex insurance affordability

programs so that all consumers working with any of these entities are provided with accurate, timely and unbiased information regarding health coverage through the Exchange.

ACAP urges CMS to implement these recommendations for the federal Exchange as well.

Part 155, Subpart D – Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

Section 155.302 – Options for Conducting Eligibility Determinations

In this Subpart, CMS describes Exchange eligibility functions, including those related to providing eligibility assessments or determinations for individuals eligible for Medicaid and CHIP. Unfortunately, the approach that CMS takes in the Interim Final rule in section 155.302 differs substantially from the provisions in the NPRM published in the summer of 2011, as well as from the spirit of the Affordable Care Act.

By allowing states to decide that Exchanges will not be authorized to make Medicaid eligibility determinations, but rather only to "screen and refer," the interim final rule raises concerns at ACAP that the concept of "no wrong door" for applying for health insurance coverage will be substantially damaged. "Screen and refer" unnecessarily bifurcates the eligibility process and increases the chance that individuals will be lost in the process and experience gaps in coverage. Moreover, with the possibility that applicants may receive communications from organizations to which they did not apply, we are concerned that they may not recognize the nature of the communication and will fail to respond as necessary to complete the application process. Overall, establishing such a process will damage the ability of the Affordable Care Act to realize its promise of health care coverage.

ACAP strongly encourages CMS to reaffirm its commitment to seamless, fully-integrated eligibility systems that provide all health care consumers with "no wrong door" eligibility and enrollment services.

We do recognize, however, that not all states will have fully operable Exchanges by January 1, 2014, and that the use of the "screen and refer" process may make it easier to stand up a state's Exchange more quickly. To accommodate the short time-frames that many states are facing, we understand that CMS may need to allow interim eligibility systems. We do not agree that states and CMS should rely upon the bifurcated systems indefinitely.

ACAP therefore recommends that states be permitted to establish the "screen and refer" process outlined in section 155.302 of this section on an interim basis only. We believe that this interim time period can be no longer than three years and that there must be demonstrable progress toward full implementation during that time period.

As we describe in our letter response to the interim final regarding *Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010*, we believe that CMS should require states to demonstrate that their Medicaid agencies either have the capacity to conduct eligibility determinations in compliance with the final Medicaid eligibility rule or are moving in that direction and will be able to meet this requirement by the end of the interim time period. Moreover, states should be required to

demonstrate that they are able to process eligibility determinations without any re-verification of existing data. Similarly, to minimize the possibility that the Exchange and the state agency will arrive at differing eligibility determinations and/or that the state will re-do the eligibility assessment using different standards, the Exchange should be required to use the same rules engine definitions and criteria as the state does.

> **In the event that CMS decides to retain the bifurcated eligibility process currently outlined in the interim final regulation, or allows it only on an interim basis as we have recommended, ACAP recommends that CMS require states to demonstrate the ability to effectively manage such a situation.**

Section 155.305(g) – Eligibility for Cost-Sharing Reductions

In section 155.305(g), CMS describes on an interim final basis the process an Exchange must use to determine an individual eligible for cost-sharing reductions. This section recognizes the complexity this benefit will hold for family units covered by a single QHP policy but who live in multiple tax households, and requires that such families receive the lowest cost-sharing reductions applicable to any family member.

ACAP harbors concerns that this rule will prevent low-income individuals from receiving the full extent of the benefits to which they are entitled.

> **As such, ACAP encourages CMS to make enrollment in the cost-sharing reduction program seamless for all households—even those covered with other tax households under a single policy—and ensure that all health care consumers obtain the full amount of cost-sharing benefits for which they are eligible. ACAP further asks that the Exchange notify households when they do not receive the full amount of cost-sharing reduction for which they are eligible.**

Section 155.310(e) – Eligibility Process, Timeliness Standard

In this section, CMS requires that the Exchange determine eligibility "promptly and without undue delay," but does not further define these terms. Meanwhile, with the Medicaid eligibility interim final rule, CMS reinstituted existing timeliness requirements (i.e., 90 days for individuals with disabilities and 45 days for other applicants). ACAP believes that there is nothing in either interim final regulation that makes it clear that states are expected to move toward on-line, real-time eligibility determinations.

The massive investment in new eligibility systems and information data hubs which the federal government is supporting should demonstrably improve the timeliness of the eligibility process. As such, **ACAP recommends that the final regulations recognize these investments and incorporate the following components:**

- **Regulations should clearly state that the overall goal is to move toward real-time eligibility determinations for the vast majority of applicants**. Regulations should, therefore, require that State Plans outlining timeliness standards incorporate a timeline for

achieving this goal. **ACAP recommends that there be a three-year maximum time period for a state to achieve this goal, meaning that states would need to achieve seamless "no wrong door" service by 2017.**

- Prior to attaining the above-stated goal, states should still be required to meet improved timeliness standards. **ACAP recommends that CMS describe specific maximum processing timeframes for states on an interim basis, until fully integrated systems are achieved in 2017.**

Section 155.340(d) – Administration of Advance Payments of Premium Tax Credits and Cost-Sharing Reductions, Timeliness Standard

In this section, CMS describes the processes an Exchange must use to ensure that an eligible individual receives the premium tax credits for which she is entitled. These processes include transmission of eligibility, enrollment and employer information from the Exchange to HHS; notification and transmission of information from the Exchange to QHPs; as well as other functions. Section 155.340(d) requires that all such transmissions occur "promptly and without undue delay," and as in section 155.310(e), CMS does not further define these terms.

Again, ACAP urges CMS to adhere to the spirit of the Affordable Care Act and strive toward demonstrably improving the timeliness of the eligibility process.

ACAP urges CMS to adopt and require a clear standard for timeliness for the transmission of eligibility information related to premium tax credits.

ACAP further asks CMS to require these transfers to occur in real-time and to set a clear timetable in the final rule for achieving real-time determinations of eligibility for premium tax credits and cost-sharing reductions.

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

This section requires the Exchange, Medicaid and CHIP agencies, and the BHP to coordinate efforts related to determining eligibility to ensure that the burden on individuals is minimized and that eligibility determinations occur promptly and without undue delay. We wrote previously in this letter that by allowing states to opt to "screen and refer" instead of fully determining eligibility, CMS raises substantial concerns for ACAP that the concept of "no wrong door" for applying for health insurance coverage will be substantially diminished, increasing the opportunities for individuals to experience gaps in coverage and care and confusion related to the eligibility process. Furthermore, we recognize the importance of a good customer experience to the overall success of Affordable Care Act to realize its promise of health care coverage, and fear that a bifurcated process will harm this success.

ACAP again strongly encourages CMS to reaffirm its commitment to seamless, fully-integrated eligibility systems that provide all health care consumers with "no wrong door" eligibility and enrollment services.

ACAP also recommends that CMS clarify that the agreements referenced in section 155.345(a) on the delineation of eligibility determination responsibilities held by the Exchange, the Medicaid agency, CHIP and the BHP must be approved by CMS and must be readily available to the public on the websites of all participating agencies, including the Exchange and CMS's website, not simply available to the Secretary of HHS upon request. The public should also be given opportunities to provide input on these agreements and any major changes to such agreements in the future.

Lastly, **ACAP recommends that, if a state elects (for however long permitted by regulations) to have its Exchange merely conduct a preliminary "assessment" of potential Medicaid eligibility and then relinquish the final eligibility determination to the Medicaid agency, CMS should encourage or require the Exchange to determine a child or pregnant woman to be presumptively eligible for coverage in Medicaid and/or CHIP.**

These individuals should be immediately enrolled in the program and, as appropriate, in a managed care plan, for the duration of the determination process. While such a requirement would not eliminate the problems created by fragmented eligibility systems, it could go a long way toward mitigating the negative effect on children and pregnant women.

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 while improving the efficiency and reducing administrative burdens associated with Medicaid eligibility determinations. We thank you for considering our comments, which we believe, if adopted, would promote the spirit of the Affordable Care Act and help ensure that all eligible health care consumers have access to the coverage and care to which they are entitled under the law. ACAP is prepared to assist the agency with additional information as needed.

If you have any additional questions or comments, please do not hesitate to contact me (202-204-7509 or mmurray@communityplans.net) or Jennifer Babcock (202-204-7518 or jbabcock@communityplans.net).

Sincerely,

Margaret A. Murray
Chief Executive Officer

Attachments