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Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health & Human Services

Submitted electronically via: FFEcomments@cms.hhs.gov

To Whom It May Concern:

The Association for Community Affiliated Plans (ACAP) thanks you for providing us with an opportunity to comment on the draft *Letter to Issuers on Federally-facilitated and State Partnership Exchanges*. This draft letter was published March 1, 2013 on the CMS.gov website. ACAP thanks CCIIO for its efforts to provide clear, practicable guidance for states and qualified health plans (QHPs) for participation in the Exchange in 2014.

We appreciate your willingness to consider our comments.

ACAP is an association of 58 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 24 states. Our member plans provide coverage to almost 10 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible individuals. Nationally, ACAP plans serve roughly one-third of all Medicaid managed care enrollees. Many 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. Many ACAP members currently are building qualified health plans that will participate in the Exchanges operating in their states.

The draft Letter covers a wide array of topics; we have opted not to respond to all of them, but have restricted our comments to those issues that currently concern us most. The Annual Letter will be very helpful to all issuers intending to offer qualified health plans (QHPs) in the Exchange; we very much appreciate the effort that went into it and are grateful for the enhanced detail it provides to many issues previously covered in regulation. That said, we have identified a fair number of topics for which CMS offers guidance in this Letter that is vague and may lend itself to uneven or subjective application. Because it is critically important that all QHPs operate on a level playing field, we strongly suggest that CMS provide clarity in these areas.

Our positions are explained below:

Former Chapter 1, Section 3: Essential Health Benefits
Subsection ii, *Non-discrimination in the Provision of Essential Health Benefits*

> This section, which describes how CCIIO will monitor for discrimination in the manner in which QHPs provide Essential Health Benefits, includes the following language related to exclusions and exceptions:

> "For example, discriminatory language could involve reduction in the generosity of a benefit in some manner or structural barriers to access or coverage for subsets of individuals that are not based on clinically indicated common medical management techniques."

It is ACAP's feeling that this language is overly vague. In general, ACAP supports clarity in standards to avoid differing interpretations and prevent unintentional unleveling of the playing field. QHPs will require a clear understanding and examples of what will constitute structural barriers to access, and what "in some manner" will mean to CCIIO regulators.

> **ACAP respectfully requests clear definitions and examples for CCIIO's view of discriminatory benefit design.**

In the same section, CCIIO writes that "CMS will allow issuers to address any benefits flagged as potentially discriminatory during CMS's review by providing an opportunity to modify any flagged benefit field(s) or submitting justifications."

Again, ACAP feels that plans will need additional guidance and transparent and timely communication of how CCIIO will identify discriminatory designs. For example, will CCIIO employ algorithms to "flag potentially discriminatory benefits," or will this function be accomplished by other means, such as the individual judgment of regulators? We ask CCIIO to explain this process more fully.

> **ACAP respectfully requests CCIIO to clarify with precision how discriminatory benefit designs will be flagged.**

Chapter 1, Section 3: EHB Prescription Drug Coverage
Subsection i. Drug Count Services

This section describes the regulatory requirement for health plans providing essential health benefits "to cover at least the greater of 1) one drug in every United States Pharmacopeial Convention (USP) Model category and class, or 2) the same number of prescription drugs in each category and class as the EHB-benchmark plan. "

In our letter commenting on the draft EHB rule, ACAP stated our concerns that covered individuals with significant health care needs may be prevented by this policy from accessing drugs they need to preserve and improve their health. In that letter, we requested CMS to articulate a stronger policy for comprehensive coverage of drugs for people with chronic illnesses, and would like to do so here as well.

> **ACAP asks CMS to provide stronger requirements for comprehensive drug coverage for individuals with chronic illness.**

Subsection ii. Prescription Drugs Exception Policy

This request may be accommodated by the policy articulated in Subsection ii, Prescription Drugs Exception Policy. In this subsection, CCIIO writes that "a health plan providing EHB must have procedures in place that allow an enrollee to request and access clinically appropriate drugs not

covered by the health plan." CMS continues by recognizing that most commercial health plans already have an exceptions process in place, and gives these plans leave to continue to use their current processes, so long as they allow enrollees to request both an internal and an independent review of the exception request. CMS suggests this process, but if it is not used, it is not clear what will be considered acceptable. If the state is not enforcing this provision, it is unclear if CMS intends to enforce based on the process outlined in this section, or if it review each QHP issuer's process and determine if it is acceptable on an individualized basis. ACAP asks CMS to identify exactly what standard will be used.

ACAP supports efforts to ensure that enrollees can receive clinically appropriate drugs not otherwise covered by the health plan, but seeks clarity regarding the processes CMS will use to approve and monitor exceptions.

In Step 1 of the review process for drug exclusions described by CMS in this section, Intern reviews, CMS states that the "issuer would consider an exception request (made verbally or in writing within 60 calendar days following notification of the denial." ACAP believes that most health plans could handle this step within 30 days. Shortening this window may also ensure that enrollees' needs are met and care is not delayed.

ACAP encourages CMS to consider shortening the window for issuers to consider drug exception requests from 60 to 30 days.

Step 2 of this review process, Independent reviews, states that an independent review entity (IRE) contracted by the issuer to review the exception request denial would have to make a decision within 60 days. ACAP wishes to know whether CMS has issued or plans to issue standards regarding these IREs. If plans are allowed to maintain existing relationships with review entities currently employed for other external reviews, CMS should make this clear in the final QHP Annual Letter.

ACAP seeks additional information on CMS standards related to IREs.

Chapter 1, Section 4: Actuarial Value

In this section, CMS recognizes the existence of "unique plan designs" for which the AV calculator may not be workable. CMS provides two alternative methods of calculating AV for those plans, including allowing them to "Make adjustments to certain key plan design features to input a modified plan design that fits into the parameters of the AV Calculator, and have an actuary certify that the plan design was appropriately fit into the parameters of the AV Calculator… ." ACAP asks CMS to clarify this option, which appears to allow for alteration of the plan to make the AV calculator come up with a value that an actuary would certify would be identical to the actual plan design being offered. This practice may introduce a risk that the actuarial value of these plans is not comparable to other plans employing the AV calculator.

ACAP asks CMS to clarify that the alternate method of calculating actuarial value will produce a credible, comparable result to results produced by the AV calculator.

Chapter 1, Section 6. Annual limitations on deductibles for employer-sponsored health plans in the small group market

This section provides additional guidance on AV standards for the annual limitation on deductibles for health plans offered in the small group market. In the second paragraph of this section, CMS recommends that "states collect general compliance information through market-wide targeted audits or an alternative state-based enforcement of this provision," and then states that "where CMS is reviewing plans for compliance with AV standards, CMS will be reviewing plans that exceed the deductible to determine if the plan reasonably meets the desired metal tier." ACAP asks CMS to clarify when these (and all other reviews), will occur, and at what intervals. If the reviews are anticipated to be random, health plans should be made aware of this fact. Health plan issuers will operate optimally when requirements and timelines are clear.

ACAP asks CMS to clarify the dates and intervals for compliance reviews of QHPs.

Chapter 2: Additional Standards for Qualified Health Plans, **Section 1. Network Adequacy and Inclusion of Essential Community Providers**
ii. Essential Community Providers

This section provides guidance on requirements for QHPs to contract with Essential Community Providers (ECPs). ACAP represents many Safety Net Health Plans that enjoy strong affiliations with safety net providers such as Federally-Qualified Health Clinics, public hospitals, children's hospitals, and others. We strongly support the ECP provision in the Affordable Care Act and ensuing regulations.

The Annual Letter provides the following guidance:

- **Safe Harbor Standard**. … The issuer application must demonstrate that at least 20 percent of available ECPs in the plan's service area participate in the issuer's provider network(s). In addition to achieving 20 percent participation of available ECPs, the issuer offers contracts before the start of the coverage year to all available Indian providers in the service area, and at least one ECP in each ECP category (see Table 2.1) in each county in the service area, where an ECP in that category is available.

While ACAP strongly supports inclusion of ECPs in every QHP's network, some Safety Net Health Plans harbor concerns with the Letter's approach. For example, some plans with strong safety net relationships do not, for various reasons, currently contract with some types of ECP providers. The providers may not have the capacity to contract with the plans as Medicaid managed care organizations, for example. Further, some Safety Net Plans expressed worry about the requirement that a contract be offered to "at least one ECP in each ECP category" where such category is available. However, CMS's use of the standard of *offering* rather than holding fully executive contracts may provide both providers and plans time and leeway to negotiate a mutually-beneficial contract. ACAP suggests that CMS recognize when a plan has made a good faith effort to contract with all necessary ECPs, and accommodate a written or verbal explanation of such effort.

Also, CMS includes this sentence in the section: "CMS may verify the offering of contracts after certification." Because of uncertainty related to which providers will be considered ECPs (see next point) and other timing challenges, and because providers are not incentivized to hold to the QHP certification timeline in establishing contracts, ACAP appreciates and supports this approach.

Lastly, ACAP urges CMS to release the promised list of ECPs as soon as possible so that QHPs may assess their network-building efforts against this benchmark.

ACAP supports the ECP requirement and policy. In light of potential challenges in achieving contracts with every type of ECP, ACAP urges CMS to recognize good faith efforts on behalf of QHPs to work with ECPs in their service areas.

ACAP supports CMS's decision to verify QHP offers of contracts after QHP certification.

ACAP urges CMS to release the non-exhaustive list of ECPs as soon as possible.

Chapter 2, Section 2. Accreditation

This section provides additional guidance on accreditation requirements for QHP issuers seeking certification in an FFE, including a State Partnership Exchange. ACAP strongly supports the phased-in approach to accreditation, as submitted to CMS in various response letters to draft rules.

CMS writes that issuers will also be asked to upload their current and relevant accreditation certificates issued by either NCQA, URAC, or both entities, so that the Exchange may verify the accreditation information. The Letter indicates that for 2014, the Exchange website will display the accreditation status of a QHP issuer in one of the following ways: "Accredited by NCQA," "Accredited by URAC," "Accredited by NCQA and URAC," or "Not yet accredited" if an issuer is accredited on any of its existing products by one of the currently recognized accrediting entities. ACAP recommends that CMS state that "Accreditation is in process" for plans without accreditation, rather than using "Not yet accredited."

Based on the phased-in approach, QHPs serving the Exchange in 2014 will have had to schedule an accreditation survey, suggesting that the accreditation process is underway. This language is more positive than "Not yet accredited," and suggests that the QHP is operating under CMS rules.

ACAP recommends CMS use "Accreditation in process" rather than "Not yet accredited" on the Exchange website.

For open enrollment beginning on October 1, 2013, an Exchange website will display selected CAHPS survey results from an issuer's accredited commercial product lines when these existing CAHPS data are available for the same QHP product types and adult/child populations. CMS writes that it will display the two CAHPS Global Ratings for the health plan and health care, and results from one access to care measure. ACAP has already shared our position with HHS that the CAHPS survey must be translated and validated in languages other than English and Spanish in a

culturally competent manner in order to adequately capture enrollee attitudes toward their health plans. We echo those thoughts in this letter.

As CMS intends to post plan CAHPS scores on the Exchange website, ACAP urges CMS to translate and validate the CAHPS survey in languages in addition to English and Spanish.

Chapter 2, Section 3. Non-Discrimination by QHPs

This section addresses how CMS will review QHPs for compliance with non-discrimination standards that apply to QHPs. States participating in a State Partnership Exchange may use a similar approach. In this section, CMS writes that "to ensure non-discrimination in benefit design, CMS will perform an outlier analysis on QHP cost sharing (e.g., co-payments and co-insurance) as part of QHP certification. QHPs identified as outliers may be requested to modify certain benefits if the outlier benefits have the effect of discouraging the enrollment of individuals with significant health needs." CMS identifies a list of benefits for which an outlier analysis will be conducted, and also explains that it will review information contained in the "explanations" and "exclusions" sections of the plans and benefits template, seeking language that involves a reduction in generosity of benefits not based on clinical evidence for some individuals.

As we describe in an earlier section of this letter, ACAP worries that this guidance – and other similar guidance – is overly vague and open to a high level of subjectivism. We recommend that CMS build clearer standards or processes for its own review of plans for discriminatory benefit design to avoid unwittingly creating an uneven playing field for some plans.

ACAP recommends that with regard to monitoring for discriminatory benefit design, CMS clarify its own standard for review.

Chapter 3: Qualified Health Plan Certification Process in FFEs, including State Partnership Exchanges, Section 1. QHP Application and Certification Process in Non-Partnership FFEs Subsection i. Issuer Data Collection and Coordination with States

Among other items, CMS describes in this section how it will coordinate with states to ensure that state-specific review guidelines and procedures are consistent with applicable federal law and operational deadlines. The Affordable Care Act requires that QHP issuers be licensed and in good standing to offer health insurance coverage in each state where the issuer offers health insurance coverage.

ACAP seeks additional clarity regarding the meaning of "good standing." We understand this to be defined by the state. Specifically, we would like to know whether a plan under a corrective action plan, could or would be determined by the state to be in good standing.

ACAP seeks additional clarity regarding the meaning of "good standing."

Chapter 3, Section 1. QHP Application and Certification Process in Non-Partnership FFEs

In this section, CMS indicates that starting March 1, issuers will be allowed to submit requests for Plan IDs to the Health Insurance Oversight System (HIOS). We are aware that the Affordable Care Act also requires all health plans to apply for a Health Plan Identifier (HPID). ACAP plans would like CMS to clarify whether these identifiers are the same or different, and how the requirements for applying for and receiving them differ.

ACAP asks CMS to clarify whether plan IDs for HIOS and the HPID required of all plans are the same or different.

Chapter 3, Section 3. QHP Agreement.

This section describes how CMS will conclude QHP certification in all FFEs, including State Partnership Exchanges. CMS writes that the signed QHP agreement concludes the QHP certification process, and that "a single QHP Agreement will cover all of the QHPs offered by the issuer in a state." CMS will release a copy of the QHP Agreement in the spring of 2013.

ACAP plans have expressed concerns that one agreement can meet the needs of all QHPs regardless of whether plans are commercial, for-profit, nonprofit, or governmental. Plans wish to know whether they will have an opportunity to review the agreement in spring 2013 before it is considered final for coverage year 2014. Plans also wish to know whether they will have an opportunity for review prior to final execution of their own agreements, and whether there will be an opportunity to tailor or edit the agreement to each plans' particular needs, restrictions and requirements.

ACAP seeks additional information regarding the final QHP agreement, including whether the agreements will be tailored to the individual plan and whether plans will have an opportunity to review.

CMS also writes that in order for QHPs to be available on the Exchange to potential enrollees during the initial open enrollment period, issuers must sign and finalize agreements with CMS in early September. ACAP plans wish to know if this is their final opportunity to decide whether to participate in the Exchange or not, assuming they have undergone the QHP certification process to that point.

ACAP seeks clarification from CMS regarding whether signing the QHP agreement is the final opportunity to decide whether or not to serve the Exchange.

Chapter 3, Section 4. FFE QHP Annual Review and Recertification

This letter states that QHP certification is good for one year, and that after that period a QHP must undergo a recertification process. We understand that CMS is now developing this process and we will have an opportunity to review it during future rulemaking. We urge CMS to develop an expedited application process which will allow plans to indicate "no change" where possible, requiring more complex updates only in limited places, such as rates and benefits.

ACAP asks CMS to develop a simple QHP recertification process to minimize burden on QHPs.

Chapter 4: Qualified Health Plan Performance and Oversight, Section 1. Account Management

In this section, CMS reiterates that each issuer participating in the FFE will be assigned an account manager, who will serve as the issuer's primary point of contact at the Exchange. ACAP wishes to know who this manager will be. Will she be employed by CMS, a contracted entity, or another type of organization? What standards for access to account managers for issuers will be established?

ACAP seeks additional information regarding QHP account managers.

Chapter 4, Section 2. QHP Issuer Compliance and Oversight

In this section, CMS writes that QHP issuers will be asked to submit a Compliance Plan as part of the QHP Application. The plan will provide critical information, including how a QHP intends to adhere with regulations and guidelines, and prevent fraud, waste and abuse. Although the compliance plan will not be required of issuers, CMS asserts that compliance plans are an important part of a QHP's performance, and that the information therein will help CMS reach the decision to certify the plan.

ACAP believes that CMS should not deem a critical part of the application process to be optional. Allowing this element to be option raises the potential for an unlevel playing field among issuers. It is unclear whether choosing to submit such a plan will be beneficial or detrimental to an issuer's application.

ACAP urges CMS to set a consistent standard for QHP applicants regarding whether or not a compliance plan is required.

Chapter 6: Consumer Enrollment and Premium Payment, Section 6. Grace Periods for Non-Payment of Premiums

We recognize that the Affordable Care Act provides a three-month grace period to individuals who do not pay their premiums. ACAP has reviewed the Exchange Final Rule and this Letter, both of which provide guidance to issuers who must terminate coverage for enrollees who fail to pay premiums; both have raised questions and concerns for Safety Net Health Plans.

First, the rules and Letter make clear that the grace period only applies to those individuals who have already paid their share of one month's premium. Can the one month be any month or does this language refer to the most recent month adjacent to the months with no premium payment?

Second, is the most recent paid month included in the three month grace period, so that coverage is only for the month that is fully paid? If so, will the QHP be required to return advanced premium tax credits only for months two and three of the grace period?

Also, recognizing that QHPs are to forewarn providers as soon as possible that a member has trigged a grace period, there is some concern that providers may demand up front payment from enrollees or stall services.

In addition, recouped payments to providers could be significant in amount, and could be a serious source of discontent Exchange providers and between providers and plans.

Lastly, although we understand that the Affordable Care Act provides the three-month grace period only for recipients of premium tax credits, the need for QHPs to operate two different processes for terminations for nonpayment of premiums will be administratively burdensome.

ACAP seeks clarity and expresses some concern regarding the three-month grace period policy.

Chapter 6, Section 7. Notice Requirements
Subsection ii. Notice of Pending Claims—to Providers

This subsection reiterates the regulatory requirement that issuers notify all providers that may be impacted by an enrollees grace period, including that claims incurred may not be reimbursed. Although the Annual Letter suggests notice should go at least to providers that submit claims for services rendered during the grace period, it stands to reason that providers that will potentially serve the enrollee would benefit from this information. Plans cannot be expected to notify all network provider; ACAP seeks additional clarity on the basis for notice for such notice to providers.

ACAP seeks information from CCIIO related to which potentially-impacted providers should be notified that an enrollee has triggered a grace period for premium nonpayment.

Chapter 6, Section 10. Agents and Brokers.

In this Section, CMS describes how it will work with agents and brokers to facilitate enrollment in both the individual and small business Exchanges, to the extent permitted by state law. ACAP plans seek clarity on several issues related to agents and brokers in relation to the Exchange.

First, issuers should be given an opportunity to review the CMS/Broker agreement. In addition, issuers need more information regarding how brokers and agents will operate, particularly with regard to whether a broker with whom an issuer is not contracted will be able to enroll a member in the issuer's QHPs, and how issuers will be made aware of which brokers have sold their products to enrollees. Will issuers, for example, obtain an "agent of record" form from enrollees or the Exchange so that issuers may know whom to pay commissions? In addition, ACAP seeks information regarding rules governing broker fees paid by insurers.

ACAP seeks additional information related to how agents and brokers will operate in relation to the Exchange and QHPs.

Chapter 7: Consumer Support, Section 1. Call Center and Website

The Annual Letter states that the website supporting FFEs and State Partnership Exchanges "will be 508 compliant, designed to accommodate people with disabilities according to federal requirements," and will support a number of critical program topics in both English and Spanish. Because we anticipate that the Exchange-eligible population will be extremely diverse in terms of language, we expect that making key program information available in Spanish and English only will be insufficient, and we urge CMS to provide this information in additional languages.

ACAP urges CMS to provide key information on the Exchange website in languages in addition to English and Spanish.

Chapter 7, Section 3. Provider Directory

Both previously-released regulations and this Annual Letter describe the requirement that QHPs to make their provider directories available to the Exchange for publication online by providing the URL link to their network directory. This Letter describes CMS's expectations that the directory to include "location, contact information, specialty and medical group, and any institutional affiliations for each provider, as well as additional information.

Although these pieces of information are important to potential enrollees, some Safety Net Health Plans do not currently list all of these elements in their provider directories. For example, a plan not currently listing institutional affiliations for providers will have to undertake substantial work to bring its directory into compliance and keep it current. We suggest that CMS allow plans a grace period to redevelop their directories according to this guidance. We also ask that CMS recognize that requiring this particular information in printed directories will add substantially to their format and length.

ACAP requests that plans be allowed a grace period to redevelop provider directories to meet CMS requirements.

Chapter 7, Section 5. Coverage Appeals

The Annual Letter indicates that "QHPs are required to meet the standards for internal claims and appeals and external review established in 45 C.F.R. § 147.136, which codifies section 2719 of the PHS Act. This section of the law states that issuers offering group or individual health insurance coverage implement "an effective process for internal claims appeals and external review." CMS intends to monitor the effectiveness of QHP issuers' appeals processes.

ACAP seeks clarification on this section. We assume that this language implies that the appeals and grievance process will be the state's DOI specified process. If this is not the case, CMS should clarify in the final version of the 2014 Annual Letter. In addition, ACAP wishes to know how CMS will monitor this process and the frequency with which it will do so.

ACAP seeks clarity regarding the requirements for internal and external appeals for QHPs.

Chapter 7, Section 6. Meaningful Access

The Exchange regulations and this Annual Letter state that "in order to ensure meaningful access by limited-English proficient speakers and by people with disabilities, the Exchange Final Rule requires that QHP issuers provide all applications, forms, and notices to enrollees in plain language and in a manner that is accessible and timely to individuals living with disabilities and individuals with limited English proficiency." Some ACAP members have suggested that for the sake of consistency and reducing burden on QHPs, CMS adopt the Medicare Advantage Prescription Drug standards for meaningful use.

CMS outlines a safe harbor standard for meaningful use related to language access and access for individuals with disabilities. ACAP members indicate that these standards may exceed what is required in Medicare and Medicaid and therefore could be burdensome on QHPs. ACAP reiterates that adopting meaningful use standards employed for existing programs would reduce burden on QHPs.

ACAP recommends that CMS adopt meaningful use standards for the Exchange that are already in use for other programs for the purpose of reducing burden on QHPs.

Conclusion

ACAP thanks CMS for your willingness to discuss these issues with us. If you have any additional questions or comments, please do not hesitate to contact Jenny Babcock (202-204-7518 or jbabcock@communityplans.net).

Sincerely,

Margaret A. Murray
Chief Executive Officer