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Association for Community Affiliated Plans

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Jay Angoff
Director
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
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Submitted electronically via: *http://www.regulations.gov*

Dear Mr. Angoff:

The Association for Community Affiliated Plans (ACAP) appreciates this opportunity to provide comments in response to the request from the Office of Consumer Information and Insurance Oversight (OCIIO) regarding the Exchange-related provisions in Title I of the Affordable Care Act (ACA).[1]

ACAP is an Association of 52 not-for-profit and community-based Safety Net Health Plans.[2] Our member plans provide coverage to over 7 million individuals enrolled through Medicaid, Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dual eligibles. Nationwide ACAP plans serve one of every four Medicaid managed care enrollees. The strong support and participation of Safety Net Health Plans has played a critical role in the expansion of health coverage. Under the ACA, Safety Net Health Plans must be viewed as a full partner in meeting the coverage needs of Americans – whether they are eligible for Medicaid, CHIP or if they access coverage through the Exchange.

ACAP's members have identified several issues critical to ensuring access to affordable quality health care coverage that will effectively meet the needs of individuals and families accessing health coverage through the new Exchanges. Our comments and questions can be summarized in the following five main themes:

- Exchanges must be designed to provide options that offer the best value for low income consumers, including individuals and families who will newly access coverage through the Exchange and those who may transition out of Medicaid in the future.
- Whether it is administered by a state or the U.S. Department of Health and Human Services, the Exchange structure must be flexible enough to ensure that Safety Net Health Plans are

[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 (ACA).

[2] ACAP represents safety net health plans that are exempt from or not subject to federal income tax, or that are owned by an entity or entities exempt from or not subject to federal income tax, and for 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).

allowed to participate if they choose. That is, federal and state regulations should not erect barriers to participation that would disproportionately impact the ability of Safety Net Health Plans to participate in the Exchange.

- Exchanges should encourage and support continuity of coverage for individuals and families that may shift between the Exchange and other sources of coverage, such as Medicaid and CHIP.
- Exchanges should look to build on existing Medicaid and CHIP systems, processes, and policies, which are familiar to consumers who will be interacting with the Exchange.
- As the Exchanges are designed and developed for each state, there must be a robust process for stakeholder input which will allow for the design of a highly efficient Exchange that connects individuals with the most appropriate coverage.

Value of Safety Net Plans in the Exchange

Safety Net Health Plans will add value to the options for coverage for many consumers who currently access their health care through these plans. Therefore, from the beginning there should be no limits on the type of health plans that enter the Exchange market – even if there are limits on the number of plans.

Safety Net Health Plans serve low-income and underserved populations and contract with providers, such as community health centers, safety net hospitals, and others who work with these vulnerable populations. Furthermore, Safety Net Health Plans are closely connected to their communities and frequently offer a wider array of services beyond health care in order to help with the overall well-being of the consumers they serve. Because of the role that safety net plans have played in serving vulnerable populations, they stand to have a natural and important function in the design and implementation of the Exchanges. This is especially true in the areas of coordination between the Exchange and Medicaid and CHIP, and designing products for the subsidized individual consumers, many of whom may have multiple touch points with the public health care programs.

Safety Net Health Plans participating in Medicaid must meet stringent state network requirements that require timely access to a network of primary care and specialty providers. In turn, access to care is a key component of the quality measurement set for health plans and ensures ongoing accountability. Safety Net Health Plans also are dedicated to high quality health care and transparency in quality measurement as a vital component of continuous quality improvement.

In addition, Safety Net Health Plans have the expertise necessary to help ensure continuity of care for persons moving among public programs due to income fluctuations, and to cover children in a family who may qualify for different programs due to age or citizenship status. This expertise will be particularly valuable given the number of individuals that are expected to fluctuate between Medicaid eligibility and subsidized coverage through the Exchange.

Administrative Simplification of the Exchange

To improve efficiency and effectiveness, the new Exchanges should adopt policies and administrative systems which simplify the experience for consumers. The Exchange has the potential to be confusing for many consumers who may be unfamiliar with insurance and may have difficulty choosing and enrolling in a health plan. Designating the Exchange as the single point of entry and “one-stop-shop”

for health care coverage would help create a seamless experience for consumers. For example, in Massachusetts the exchange entity – the Health Connector -- collects premiums and processes enrollment which has simplified the process for individual consumers. Centralizing certain Exchange functions also will reduce duplicative administrative costs and, as a result, are likely to lower premiums for Exchange consumers.

Alternatively, another approach is for the state to assess its existing Medicaid program systems and functions to dovetail as many of the Exchange administrative functions as possible with the current Medicaid functions and requirements. For example, maintaining the same complaint and appeal process, the same telephone performance standards, the same provider access standards allows regulators to use existing measures, which are already in place for Medicaid and CHIP Plans. Streamlining administrative functions within the Exchange also would help to simplify the process for consumers and insurers.

In addition, the Exchange should work with plans, including Safety Net Plans, to identify and develop certain uniform data standards. For example, a uniform standard for the network file will be most effective, both for the plans and for the Exchange to evaluate the adequacy of plans' networks. Today, many States have such a format developed for their Medicaid Managed Care enrollment processes.

Comparability and Value in Benefit Design

Simplicity and clarity of product offerings on the Exchange are issues central to the consumer focus expectations of reform. Exchanges should require some measure of uniformity and limits around plan design to facilitate comparability of products and insurers so that consumers can make the best choices based upon price and quality. Standardized benefit packages will provide more clarity and more easily allow consumers to compare and contrast health plan options based on price, network, customer service, and other qualifications. To allow some degree of product differentiation that would benefit consumers, regulations should permit plans to offer value-added services in addition to the standard benefit package.

Qualified Health Plans – Access, Expertise and Value of Safety Net Plans

ACAP requests that federal Exchange regulations explicitly state that Medicaid managed care plans, including Safety Net Health Plans, are included in the universe of plans eligible to participate in the Exchange, provided all Safety Net Health Plans meet standards for quality, access, and affordability. Safety Net Health Plans currently cover 25 percent of people in Medicaid managed care; and this percentage has been steadily increasing over the last decade. Safety Net Health Plans are experienced in serving low-income and underinsured populations that will receive federal health care subsidies to access coverage through the Exchange.

Further, we strongly recommend that Exchanges leverage existing policies and procedures – and avoid duplication and the additional costs such duplication would bring – when determining whether a plan is a "qualified health plan" that can participate in the Exchange. For example, every state currently requires Medicaid and CHIP health plans to successfully complete rigorous certification processes and meet stringent quality and access standards in order to participate in either programs. While each state Medicaid agency has developed unique requirements, within many states the rigorous standards for Medicaid participation are likely to meet or exceed those for qualified health plans in the Exchange.

Thus, Exchanges should be encouraged to cross-walk Medicaid and CHIP managed care requirements and other State regulatory or licensing requirements with the requirements of qualified health plans. If a plan meets the state's Medicaid and CHIP requirements the Exchange could "deem" it a qualified health plan, rather than requiring these existing plans to go through additional and unnecessary processes. This policy also should be extended to an Exchange that is administered by the federal government.

This process would help ensure a mixture of private, for profit, and not-for-profit plans that will facilitate a more robust competitive marketplace and allow consumers to choose the most appropriate plan for them based on quality, provider network, and other key elements. Deeming will also help make certain that low income and underserved populations accessing coverage through the Exchange have the option to enroll in a Safety Net Health Plan that may be designed specifically to provide the best care possible to individuals in their community.

Continuity of Coverage

Given the volatility of employment, enrollment churning in the Medicaid program and the state Exchange can be expected for low income populations. Moving on, off and between programs can disrupt a person's access to care, so minimizing churn can benefit enrollees, as well as reduce administrative burdens on the programs. To this end and given the growing body of research that has found that continuous eligibility translates into higher quality of care for the patient, ACAP is a strong supporter of providing 12-month continuous eligibility for Medicaid eligible adults.

In addition, Exchanges should adopt policies and tools for plan selection that facilitate continuity of coverage for consumers whose eligibility will be shifting between Medicaid and the Exchange. It is widely expected that small changes in income will result in frequent changes in eligibility for Medicaid, CHIP, and subsidized coverage in the Exchange. And even a temporary loss of health coverage can have significant, adverse consequences. According to modeling conducted by the Lewin Group, nationally, on average 40% of low-income subsidized Exchange populations will be:

1. Previously enrolled in Medicaid/CHIP
2. Previously enrolled in a premium subsidy program
3. Previously uninsured (with our without family members in Medicaid)

Enrollment churning between subsidized coverage through the Exchange and Medicaid and CHIP could be disruptive to individuals' plan of care – especially important for those with chronic conditions. Medicaid Safety Net Health Plans are familiar with the churn of low-income individuals in and out of their safety net programs and the increase in service utilization that enrollment churn brings. They have programs and policies specifically designed to manage the continuity of care issues that are created by gaps in coverage. Thus, Safety Net Health Plans offer a turnkey solution to managing the effects of volatility in coverage that is possible as individuals and families cycle between the Exchange and Medicaid and CHIP. However, the best solution for consumers is to design the Exchange so that breaks in coverage and movement among various programs is minimized.

As noted above, individuals and families who were enrolled in Medicaid, CHIP or other premium subsidy programs but later access coverage through the Exchange may wish to remain with their plan. Providing this type of continuity allows families to remain under a single plan and eliminates the need

to find new providers who may not know their medical history and the treatments and services that work best. Further, approaches that support continuity of coverage reduce the need for consumers to adjust to new plan policies and procedures each month, even as their income fluctuates.

Simplified Enrollment Options for Consumers. Exchanges should prioritize enrollment processes that minimize disruption in coverage for vulnerable populations. The difficult experience of transitioning dual eligibles from Medicaid to the Medicare Part D prescription drug program offers some insight into the types of policies, tools, and procedures that may be needed to accommodate the millions of individuals who will newly be eligible for Exchange-based coverage.

As noted earlier, evaluating the various Exchange based options and enrolling may be confusing for consumers; they will need assistance understanding and identifying the best coverage options for them. One approach would be for the Exchange to prospectively assign or "nudge" individuals to a plan based on where they received their care under Medicaid. That is, if they were enrolled in a Medicaid health plan that participates in the Exchange, they would be given information to make an informed choice about which plan to choose, including which Exchange plans would allow them to keep their current providers. Enrollment material could be written to promote the idea of continuity of care with the same health plan. However, individuals would still be notified of their option to choose another plan.

In addition, the experience in Massachusetts demonstrates that families transitioning between the Exchange and Medicaid and CHIP will need assistance navigating the choices and identifying the best option for them. A similar prospective type enrollment process into a Medicaid health plan – with an opt-out—could be used to allow families to remain in a single plan, regardless of whether they are eligible for Medicaid, CHIP or subsidized coverage through the Exchange. For example, in a family whose income is 185 percent of the federal poverty level, the children would be eligible for CHIP and the parents eligible for subsidies in the Exchanges. However, many families will want to enroll in the same health plan. These families will need assistance in identifying their options and direction to the plan that meets these criteria.

Similarly, this option would also be useful in simplifying the re-enrollment process after an individual or family has a gap in coverage. Gaps in coverage may occur due to income changes, non-payment or delayed compliance with renewal requirements. In these situations individuals would automatically be enrolled into their previous plan or the plan of other household members, with the option to change plans.

ACAP also concurs with the recent statement by Cindy Mann, Director of the Center for Medicaid, CHIP, and Survey & Certification, that efficient enrollment in Medicaid and CHIP will require marrying the enrollment and renewal processes with that of the state health insurance Exchanges. In addition, Exchange Navigators will play an important role in helping low income individuals and families identify Safety Net Health Plans that have robust provider networks with federally qualified community health centers (FQHCs), public hospitals, clinics and other safety net providers in places that traditional insurance typically does not.

Quality Rating Systems

ACAP recommends that any standardized rating system for Exchange plans should account for the needs of the diverse population that will access coverage through this new entity, including low income, underserved individuals and families. Specifically, characteristics of these populations, such as individuals with multiple chronic conditions, who are homeless, have behavioral or mental health issues, or face socioeconomic or other barriers could require more plan management to improve outcomes. The Exchange rating system also should reflect the growing body of literature which documents that language, country of origin, education level, health literacy, as well as income may impact the ability to adhere to care standards and may increase plan care management requirements. Therefore, Exchange plans should not be penalized for attracting a higher proportion of such enrollees.

Regarding OCIIO's questions about current quality measures, ACAP notes that one of the challenges that Medicaid safety net plans currently are working to address is the fact that the Healthcare Effectiveness Data and Information Set (HEDIS) measures are currently not risk adjusted. While many Safety Net Health Plans are NCQA-accredited and rank highly on national quality measurements for Medicaid, they have done so through concentrated efforts with difficult to manage populations. Risk adjustment for quality measures would level the playing field as Medicaid, including Safety Net Plans, which will likely serve higher-risk members, are rated against plans with lower risk enrollees.

We also note that the experience with dual eligible Medicare Advantage Special Needs Plans (MA-SNPs) shows a disproportionate share of enrollees with cognitive disorder, mental health and substance abuse diagnoses. While MA-SNPs serving dual eligibles score on average the same as general enrollment MA plans on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and plan operational measures (health plan responsiveness, customer service and member complaints), they score lower on HEDIS and Health Outcomes Survey measures due to the health challenges faced by of low income groups. Therefore, common quality ratings metrics such as clinical outcomes and measurements and consumer satisfaction may not be the best indicators of quality for plans that treat lower income populations or they may need to be modified.

In the Exchange marketplace, the Navigator program participants will advise consumers -- and employers – about how to use the Exchange system. ACAP recommends that this education should include information on different types of health plans in the Exchange and how to value plan elements, such as provider networks.

Safety Net Exclusion from the Annual Excise Tax on Insurers

ACAP supports legislative changes to ensure the annual excise tax on insurers is not a barrier to safety net health plan participation in the Exchanges. Under the PPACA legislation, Congress recognized the special role that Safety Net Health Plans have in the health care marketplace by exempting them from the health plan excise tax if their revenues from Medicare, Medicaid, and CHIP exceed 80 percent of total revenues. However, if these plans participate in the Exchange and serve the subsidized population, their revenue mix will change. Revenues from the subsidized population are currently *not* subject to the 80 percent calculation – making Safety Net Plans potentially subject to the annual fee even though they would still be serving a low-income, federally subsidized population. ACAP respectfully requests that the exclusion from the excise tax for Safety Net Health Plans' be broadened

to include revenues from subsidized premiums and that it be extended to include for-profit subsidiaries of not-for-profit insurers (or health plans).[3,4]

Accreditation Standards

ACAP encourages Exchanges to identify appropriate accreditation policies that are inclusive of the different types of plans that wish to participate. For example, the External Quality Review Organization (EQRO) could be one acceptable Exchange accreditation standard for Medicaid health plans in states that do not require NCQA or URAC accreditation for their state Medicaid program. Alternatively, EQRO could be a transitional accreditation as Safety Net Health Plans work towards obtaining the multi-year NCQA or other required accreditation.

Exchange Service Area

Policymakers also must thoughtfully consider how to define the market or rating area of the Exchange. For example, many states, particularly most large states, have multiple service areas within the state, defined by geographic variation or population. Regulators must allow the option of creating regional-based service areas within a state to allow participation from Safety Net Health Plans.

Decisions about the service areas should weigh the implications for consumers who may currently or wish to be enrolled in a community-based plan – a plan that by definition may not serve the entire rating area defined by the Exchange. Safety Net Health Plans are by definition state and local market specific. Most do not operate in multiple states. They are often more integrated into the fabric of their community social service infrastructure and provide a community focus and connection to services and supports that are needed by the lower income subsidized Exchange population.

Exchange Financing

One option to ensure the sustainability of Exchanges beginning in 2015 is to assess a fee on insurers that participate. ACAP recommends that federal guidance encourage, and state Exchanges adopt, a fee structure that is balanced with the need to promote diversity of plans in the Exchange.

Risk Adjustment Systems

Risk adjustment systems should include risk factors that are highly prevalent in lower income populations. Risk adjustment must take into account diagnoses as well as income, language barriers,

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[3] Ibid.

[4] The Healthcare and Education Reconciliation Act of 2010, included the following exemption from the annual excise tax on insurers at Section 1406 (a)(2)(C) "*any entity— "(i) which is incorporated as a nonprofit corporation under a State law, (ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in section 501(h) of the Internal Revenue Code of 1986), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office, and (iii) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act."*

and other barriers for the populations that will be covered through the Exchange. Such systems must also account for the proportion of a plan's network that is comprised of providers that serve higher risk populations, such as community health centers, hospital based clinics, and others. As noted previously many Safety Net Plans have a lot of members who receive health care services through community health centers. The cost for these services may well be higher than non-clinic providers because the Affordable Care Act requires that federally qualified health centers (FQHCs) be reimbursed as the prospective payment system (PPS) rates for Exchange products.

CO-OP program

Safety Net Health Plans are interested in exploring how they can meet the goals and criteria of the CO-OP program given their nonprofit status and community focus. Safety net plans already serve many of the needs that CO-OPs are intended to serve and may be interested in applying for the CO-OP program loans and grants. In fact, ACAP's "incubator plan," the Maine Primary Care Association, has applied for funding to explore options around the CO-OP program, and ACAP supported this application. Other ACAP plans or emerging plans are exploring the CO-OP option as it may be a more viable pathway to participate in the Exchange.

Additional Questions for Consideration

As you continue to develop federal Exchange regulations and guidance we hope you will consider the following questions:

Will it be possible for the federal government to provide a waiver to states from certain provisions of the law to ensure the participation of Safety Net Health Plans? Are states able to make this determination without federal approval?

What policies will be applied to determine the interaction between the Exchange and the Basic Health Plan in states that take up this option? Will OCIIO consider extending the same continuity of coverage policies recommended for Medicaid?

After the initial enrollment period, could renewal policies of the Exchange and Medicaid and CHIP be tied to the birth date of the head of household?

Safety Net Health Plans have developed expertise necessary to manage the range of concerns that may not be addressed by other health care delivery systems. Through partnerships with their safety net providers, including community health centers, public hospitals, children's hospitals, and primary care providers, Safety Net Plans ensure that Medicaid enrollees have regular access to appropriate, patient centered care and to connect enrollees with the social supports they need to maintain good health. Medicaid health plans have served as the vehicle for expansion efforts in state and county health coverage expansion reform initiatives. This results in a natural fit with or extension of the mission of Safety Net Plans and the subsidized individual Exchange consumers.

ACAP and its members look forward to working with you to design the policies and framework for fully functioning Exchanges that will meet the needs of a diverse population, including vulnerable populations.

Sincerely,

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