

October 5, 2011

The Honorable Kathleen Sebelius
Secretary



The Honorable Donald M. Berwick
Administrator, Centers for Medicare and Medicaid Services

Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

**Attention: CMS-9989-P: Patient Protection and Affordable Care Act;
Establishment of Exchanges and Qualified Health Plans**

Dear Secretary Sebelius and Administrator Berwick:

Medicaid Health Plans of America (MHPA) is pleased to offer comments on the proposed rules for the Establishment of Exchanges and Qualified Health Plans under Title I of the Patient Protection and Affordable Care Act (76 Federal Register 41866, July 15, 2011).

MHPA is the leading trade association solely focused on representing Medicaid health plans. Its members' 90 managed care plans serve more than 14 million Medicaid beneficiaries in 33 states and the District of Columbia. MHPA represents both non-profit and for-profit health plans, ranging from large multi-state insurance corporations to small community-based health plans. Consistent with our October 4, 2010, response to the Request for Comments (RFC) published earlier by the Department of Health and Human Services (HHS), our comments on the proposed rules for Exchanges and Qualified Health Plans primarily focus on the intersection between Medicaid and the Exchange and policies affecting Medicaid health plans and the low-income Medicaid beneficiaries they serve.

The mission of MHPA is to develop and advance public policy that controls costs and improves access and delivery of quality health care to Medicaid members. MHPA supports the principle that every American should have access to affordable health coverage.

Our comments fall within five topics addressed by the proposed rules:

- *Maintaining continuity of care for low-income individuals*
- *Increasing affordable health coverage options through Exchange Navigators*
- *Creating a level playing field for the certification and licensing of Qualified Health Plans (QHPs)*
- *Balancing stakeholders' interests in Exchange governance structures*

- *Fair payment rates for Federally Qualified Health Centers*

Maintaining Continuity of Care for Low-Income Individuals

MHPA believes that maintaining continuity of coverage and reducing churning between Medicaid and other insurance coverage should be overarching goals for implementation of Exchanges under the Patient and Protection and Affordable Care Act (“Affordable Care Act”). This is an especially important issue for the population with household incomes below 200 percent of the Federal Poverty Level (FPL), including an estimated 16 million adults and children who will become newly eligible for Medicaid. Many of these individuals will only be employed on a part-time basis in low-wage jobs and are likely to gain and lose eligibility for Medicaid as their family income fluctuates above and below the new income threshold of 133 percent of FPL (adjusted to 138 percent of FPL using the new modified adjusted gross income, or MAGI standard).

Ideally, as we suggested in our earlier submission to HHS, states would be required to adopt 12-month continuous eligibility in Medicaid and CHIP in coordination with open enrollment periods in the Exchange. We believe this approach would help stabilize coverage for the lowest-income population that otherwise would move in and out of Medicaid coverage on a regular basis. Alternatively, a transition period could be established for a person losing eligibility for Medicaid, CHIP or Exchange coverage to allow them to continue a treatment in progress for a limited period of time. The proposed regulations do not fully address enrollment and redetermination requirements and include no provisions addressing continuous enrollment in Medicaid, CHIP, or the Exchange, or a temporary continuation of a specific course of treatment. We still, however, think these approaches are worth considering as HHS develops final rules.

We also believe that aligning redetermination periods for Medicaid, CHIP, and Exchange coverage would make it easier for individuals to transition back and forth between programs. Alternatively, we think anyone experiencing a change in income and eligibility in Medicaid or CHIP should have the opportunity to enroll in an Exchange plan during a clearly defined enrollment period.

§155.420 Special enrollment periods.

While redetermination periods are not specifically addressed in these rules, proposed §155.420(c) establishes a special enrollment period of 60 days from the date of a triggering event, which includes the loss of Medicaid or CHIP coverage. This provision also specifies that for Qualified Health Plan (QHP) selections made by the 22nd of the month, the effective date of coverage is the first day of the following month. For plan selections made between the 23rd and the last day of a given month, the effective date of coverage is the first day of the second following month.

Recommendation: MHPA supports the establishment of a uniform special enrollment period for persons losing Medicaid or CHIP eligibility. However, without providing a transition period during which a person can continue to receive treatment for an ongoing

illness or condition, and a mechanism for ensuring payment for these services, an individual may have treatment interrupted and go a month or more without necessary health care services until new coverage takes effect. We recommend that HHS add a requirement for continuation of coverage under Medicaid or CHIP until the earlier of the effective date of new coverage under a QHP plan or the expiration of the 60-day special enrollment period. We also suggest that HHS consider shortening the duration of the special enrollment period to 30 days to minimize any gaps in coverage and conform the length of this enrollment period to requirements applied outside the Exchange.

Under proposed §155.430 (d), standards for termination of coverage include a requirement that coverage under a QHP plan can only be terminated for someone becoming eligible for Medicaid and CHIP the day before the effective date of coverage. This requirement ensures that an individual will not experience a lapse in care when becoming eligible for Medicaid and CHIP and has our full support.

§156.270 Termination of coverage for qualified individuals.

The Affordable Care Act includes a provision requiring issuers to provide a 90-day grace period for non-payment of premiums by individuals receiving premium subsidies before terminating coverage. HHS is proposing to add a requirement that issuers must continue to pay claims during this period. MHPA is concerned that this requirement, in conjunction with the law's guaranteed issue requirement and the annual open enrollment period, will permit individuals to stop paying premiums for the last 90 days of each year, with no consequences. In fact, QHP issuers would be required to pay any claims and the individuals could choose a new plan during open enrollment for coverage beginning January 1.

Recommendation: *We urge the Department to carefully consider the implications of the 90-day grace period and the additional requirement for issuers to continue paying claims and recommend that HHS also include a provision preventing an individual receiving premium subsidies from enrolling in a new plan during an annual open enrollment until any delinquent premiums are paid in full.*

Increasing Affordable Health Coverage Options through Exchange Navigators

§155.210 Navigator program standards.

Under proposed §155.210(b), an Exchange would be required to provide Navigator grants to at least two of the following entities: Community and consumer nonprofit groups; Trade, industry, and professional association; Commercial fishing industry; Chambers of commerce; Unions; Resource partners of the Small Business Administration; Licensed agents and brokers; Other public entities such as Indian tribes, tribal organizations, and State or local human services.

Recommendation: MHPA and its member Medicaid health plans have extensive experience providing health care services to culturally diverse, low-income populations

and understand the important role education and outreach activities can play in expanding access to health coverage for these groups. Based on this collective experience, we are hopeful that new Navigator programs will, whenever possible, build upon and coordinate with existing Medicaid and CHIP outreach and education efforts rather than operate separate and apart from these activities. We therefore believe that entities currently providing outreach and education services to State Medicaid or CHIP agencies should also be added to this list.

Paragraph (b) also establishes eligibility standards for Navigators and would require them to meet State and Exchange licensing or certification requirements applicable to the activities they will be carrying out.

Recommendation: We believe that Exchanges should clearly articulate the roles and responsibilities of Navigators and hold them to appropriate licensing and/or certification standards based on those definitions, but should also avoid creating new, duplicative requirements administered separately from existing standards. In addition, MHPA also believes entities seeking Navigator grants should be required to demonstrate experience and competency necessary for engagement with culturally diverse, low-income populations.

Recommendation: While the preamble commentary accompanying the proposed rules suggests a State may require or permit Navigator activities to address Medicaid and CHIP administrative functions and proposed §155.210 (d) requires Navigators to acknowledge other health programs, we think HHS should explicitly require that Navigators also be able to provide prospective enrollees information on Medicaid and CHIP program requirements and help facilitate enrollment.

Creating a Level Playing Field for the Certification and Licensing of Qualified Health Plans (QHPs)

§155.140 Establishment of a regional Exchange or subsidiary Exchange.

MHPA believes regional exchanges should allow for the participation of health plans based on their established service areas and not require participation across the entire region. Regional exchanges that cross state lines could create problems for local health plans that are not licensed to serve multiple states. We understand that the requirement for health plans to serve multiple states was a significant barrier to the formation of PPOs under the Medicare Regional PPO program. The flexibility HHS permits in the proposed rule for non-contiguous states to form a region could make this even more problematic for local health plans.

Recommendation: *In order to ensure broad participation by health plans, we recommend that HHS clarify that the certification of QHPs should allow local plans to participate within their approved service areas within a regional exchange.*

§156.200 QHP issuer participation standards.

MHPA believes Medicaid health plans are well positioned to serve as Qualified Health Plans (QHPs) for individuals seeking coverage through the Exchange, particularly the low-income population that may move back and forth between the Exchange and Medicaid. Continuity of care would be improved for individuals enrolled in side-by-side plans operated by the same health insurance issuer.

However, we don't believe that Medicaid plans should be forced to operate Exchange plans since they currently operate under different sets of rules and requirements (e.g. appeals process and quality reporting) than commercial plans, have different networks of providers, and may not have the back-office capabilities needed to offer commercial products.

At the same time, we believe that any Medicaid plans choosing to seek QHP certification that can fulfill the requirements set forth in the Affordable Care Act and meet solvency and licensing requirements imposed by states on commercial plans should be allowed to participate in an Exchange.

Recommendation: We are pleased that under proposed §156.200, HHS chose to codify the certification standards included in the Affordable Care Act, including the requirement that a QHP issuer must be licensed and in good standing in each State in which the issuer offers health insurance coverage, without adding any additional standards . We are, however, concerned that paragraph (d) allows for a State to add more conditions for participation. MHPA thinks this provision should either be dropped or HHS should add a requirement that a State must demonstrate to HHS that any additional conditions of participation will not reduce choice and competition when it seeks approval of its Exchange plan. Allowing all plans that meet the Affordable Care Act's certification standards to participate in an Exchange will give consumers more coverage options at competitive pricing.

§156.295 Prescription Drug Distribution and Cost Reporting

MHPA is very concerned about QHP issuers' ability to fulfill the requirement to provide prescription drug distribution and cost reporting information as required under the Affordable Care Act. Specifically, we are concerned about the requirement to report on the amount and types of rebates, discounts and price concessions negotiated by the PBM and passed on to the QHP issuer, and the difference between the amount the QHP issuer pays the PBM and the amount the PBM pays pharmacies.

PBMs and QHP issuers have different contractual relationships, and we understand most contracts do not include explicit language requiring PBMs to make available to issuers such granular information. While a contract may require that the PBM provide issuers with information that is necessary to comply with the law, this provision is subject to interpretation and negotiation with the PBM. This information is the result of private negotiation between two parties, and as such was never meant to be publicly available.

Recommendation: We urge HHS to consider limiting or changing the data that is being requested to data that QHP issuers have the ability to provide, such as the number of prescription drug scripts filled at the mail versus retail level by plan. If HHS decides not to change the information that it is requiring QHPs to submit, we urge HHS officials to take a pragmatic approach to implementation. For example, QHPs could be given the flexibility to begin to provide this information once they are able to explicitly include this requirement in contracts with PBMs. As such, QHP issuers should only be penalized for not providing this data once they have completed their next contract negotiations with PBMs.

Balancing Stakeholders' Interests in Exchange Governance Structures

§155.130 Stakeholder consultation.

MHPA believes that when states create a governance structure for an Exchange, they should avoid establishing duplicative regulatory authorities and there should be formal, ongoing consultation with key stakeholders relevant to carrying out Exchange activities required under the Affordable Care Act, including state Medicaid agencies and Medicaid directors. Other key stakeholders that should be consulted include consumers, health plan enrollment experts, representatives of the state department of insurance, consumer advocates, providers, small business owners and health insurers and HMO's marketing within the states.

Recommendation: MHPA strongly supports the inclusion of state Medicaid and CHIP agencies as stakeholder entities that an Exchange must regularly consult. In order to help avoid the creation of duplicative regulatory authorities and improve coordination with state insurance regulators, however, the list of stakeholders should be amended to also include state insurance departments.

§155.110 Entities eligible to carry out Exchange functions.

MHPA also believes that states should include provisions that prevent conflicts of interest in any legislation establishing an Exchange governance structure as an independent state agency or as a not-for-profit entity. The proposed rules require that a majority of the board must have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group market and individual markets and the uninsured. The rules also require that a majority of the board must be free of conflicts of interest, which are defined as representing health insurers, agents, brokers, or other individuals licensed to sell health insurance.

In its preamble commentary, HHS seeks comments on the types of representatives that should be on an Exchange board to ensure that consumer interests are well represented and that the Exchange board has sufficient technical expertise. HHS also seeks comments on the extent to which the categories of representatives with potential conflicts

of interest should be further specified and on the types of representatives who have potential conflicts of interest in its requirement that a majority of board members to be free from conflicts of interest.

Recommendation: We agree that a majority of members of an Exchange governing board should have experience in the health care industry and health policy. In our view, the board should also represent a broad cross-section of stakeholders rather than a single group, such as consumers. We also don't think it necessary for HHS to list broad categories of representatives with potential conflicts of interest in its requirement that a majority of the board be free from such conflicts. Instead, states should be directed to adopt a conflict of interest policy that ensures a majority of the board is free from such conflicts of interest, regardless of any formal affiliation with a health care business or organization, which can be submitted to HHS as part of the state's Exchange plan. Alternatively, HHS should broaden the categories of entities with potential conflicts of interest to include "providers and representatives of provider organizations" to make the list more inclusive.

Fair Payment Rates for Federally Qualified Health Centers

§156.235 Essential community providers.

This provision of the proposed rules requires a QHP issuer to include within its provider network a sufficient number of essential community providers, but also clarifies that this requirement does not require any health plan to provide coverage for any specific medical procedure provided by an essential community provider. The definition of "essential community providers" is also codified.

In its preamble commentary, HHS noted a conflict between Section 1311(c) of the Affordable Care Act (PPAC), which allows a QHP decline to contract with an essential community provider if such provider refuses to accept the "generally applicable payment rate" of the plan, and Section 1302(g) of the same Act, which requires a QHP issuer to reimburse Federally Qualified Health Centers (FQHCs) at each facility's Medicaid prospective payment system (PPS) rate. In discussing this conflicting language, HHS acknowledged that QHPs utilizing FQHCs and paying Medicaid PPS rates may experience costs substantially higher than other QHPs, and that if Medicaid PPS rates exceed QHPs' generally applicable payment rates, FQHCs may be used only minimally. HHS also noted that the facility-specific determination of Medicaid PPS rates may result in complicated calculations. HHS is seeking comment on whether it should allow a QHP to negotiate mutually agreed-upon rates with FQHCs, as long as they are at least equal to the issuer's generally applicable payment rates. HHS views this as a way to help FQHCs negotiate rates higher than generally applicable plan rates without guaranteeing them the full Medicaid PPS rates.

Recommendation: Medicaid health plans include FQHCs in their provider networks and value the important role they play in delivering health services to low-income populations. However, since Medicaid PPS rates are often much higher than generally

applicable rates paid by plans and the difference is currently paid by states and the federal government with Medicaid matching funds, requiring these payment rates to be paid by QHPs may create a cost disadvantage for Medicaid plans seeking status as QHP issuers. Such a requirement might also serve as a disincentive for QHPs to contract with FQHCs since no other essential community providers would be guaranteed the same rate. We think that HHS has struck a fair balance in interpreting the two conflicting statutory provisions to allow for negotiation of a mutually agreed-upon rate that falls between the generally applicable payment rate of a QHP issuer and the Medicaid PPS rate and urge that this interpretation be codified in the final rules.

We appreciate the opportunity to comment on these proposed rules and thank you for taking our thoughts and suggestions into consideration as you develop final standards and requirements for Exchanges and Qualified Health Plans. We look forward to continuing to work with HHS officials on the implementation of provisions in the Affordable Care Act.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas L. Johnson". The signature is fluid and cursive, written over a light gray rectangular background.

Thomas L. Johnson
President and CEO