

## **RFC Responses Regarding Exchange Proposed Regulations**

1. AARP (Mary Jo George)
2. American Cancer Society (via Matt Schafer)
3. American Cancer Society – MN Chapter (Matt Schafer)
4. American Diabetes Association (via Matt Schafer)
5. American Heart Association (via Matt Schafer)
6. Blue Cross Blue Shield (Scott Keefer)
7. Care Providers of MN (Patti Cullen)
8. Fond du Lac (Phil Norrgard)
9. HealthPartners – Exchange (Stephanie Frost)
10. HealthPartners – 3Rs (Stephanie Frost)
11. John Schoenecker
12. Kathleen Picard
13. Legal Aid Society (Anne Quincy)
14. Medica – Exchange Establishment and QHP (Sarah Grcevich)
15. Medica – Exchange Regs and BHP (Sarah Grcevich)
16. MN Health Equity Working Committee (Nancy Pomplun)
17. NAMI (Sue Abderholden)
18. National Indian Health Board - Reinsurance (via Phil Norrgard)
19. National Indian Health Board (via Phil Norrgard)
20. PCG Human Services (Leigh Newman)
21. Planned Parenthood (Sarah Stoesz)
22. UCare (Edward Sheehy)
23. Will Nicholson





October 16, 2011

Assistant Commissioner Lauren Gilchrist  
Minnesota Department of Human Services  
444 Lafayette Road  
St. Paul, MN 55155

Dear Assistant Commissioner Gilchrist,

Thank you for the opportunity to provide input regarding the proposed rules titled "Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans." AARP is keenly interested in the establishment of the Exchange as this is vital to both improve access to affordable, adequate coverage for those who are uninsured, as well as to improve coverage for those already in the individual and small group markets. Please know that AARP is submitting to the U.S. Department of Health and Human Services detailed comments for proposed regulations on October 31, and will be happy to share them with you once they have been submitted.

At this time, however, we would like to share with you AARP's principles on this important issue that we hope will provide insight into the critical components needed to be addressed during the establishment and implementation of the Exchange.

### **Coordinated Processes**

AARP is a strong advocate for an Exchange that is accessible and consumer friendly. We believe the Exchange should function with ease so that a consumer can easily apply for coverage and move between coverage as one's situation changes. We strongly encourage Minnesota to develop and maintain a streamlined application process that takes advantage of the various online capabilities to determine eligibility and provide a level of coordination that the state and consumers strongly desire. Consumers need smooth integration so that timely determinations of eligibility for programs and subsidies are made and that they are enrolled in their choice of plan without gaps in coverage. The exchange must have the power to connect with other State and national entities to provide a "one stop" and seamless process for determining eligibility and effectuating enrollment for federal subsidies, Medicaid or MinnesotaCare, and other health programs.

### **Consumer Engagement**

Minnesota's exchange must be accountable and transparent. The governing board needs to act in the best interests of consumers. As the ultimate beneficiaries of the exchange, consumers should be well represented in its governance and management. The governing body's deliberations and decisions should be transparent, and should provide ample opportunity for public input.

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### **Education and Outreach**

To make the Exchange more accessible to individuals buying coverage, an emphasis must be placed upon ongoing education and outreach. This outreach should focus on understandable consumer information about coverage options, plan benefits and costs. AARP believes it is vital to make all consumer resources available in electronic and paper forms. This information needs to also be available to those with limited English proficiency.

Additionally, consumers need tools to make meaningful comparisons presented in a uniform manner. At a minimum, the Exchange should make information available that facilitates easy comparisons based on cost, quality (including patient experience), and service. Information should be available in sufficient detail to allow consumers to drill down into particular scenarios that allow them to obtain coverage facts relevant to their own or their families' health care needs and preferences.

Since many of those enrolling through the exchange may not have had insurance before and may be unfamiliar with the process of choosing a plan and applying for coverage, the Navigator program will be a critical part of this effort. The Navigator program will play an important role in reaching out to diverse groups that may be harder to reach due to language and cultural differences, or lack of familiarity with health insurance. The outreach efforts need to be sustained through reenrollment as well.

Whether through the Navigator program, consumer assistance programs, or other health insurance counseling programs, it will be important to have places where people can call and/or meet face-to-face with someone who can guide them through the process.

### **Focus on Quality of Care**

AARP believes that the exchange should ensure that all consumers have access to high quality, affordable coverage options. Minnesota should consider the public interest when certifying qualified health plans. AARP appreciates the opportunity to comment on this important issue and we stand ready to assist you in developing a successful Minnesota Insurance Exchange.

Sincerely,



Michele Kimball  
State Director  
AARP Minnesota

Cc: Commissioner Lucinda Jesson, Department of Human Services  
Commissioner Edward Ehlinger, Department of Health  
Commissioner Mark Rothman, Department of Commerce



## Threshold Questions for State Insurance Exchanges

The Affordable Care Act (ACA) creates state health benefit exchanges that will be the central marketplace for many people to compare and buy insurance plans in the individual or small-group markets. As states consider how to create and implement an exchange, these are the most important questions for them to address.

### **1. Is the exchange governance board properly structured to ensure that its decisions serve the best interest of consumers, patients, workers, and small employers?**

*Rationale:* The governance board will make the critical management and policy decisions that determine the direction and success of the exchange. It is important that the members have appropriate management to successfully make the many critical administrative decisions that must be made by 2014. It is imperative that board members not have a conflict with their business or professional interests. Other stakeholders, including patients and consumers, are best involved through advisory boards. Finally, the governance board must be held publicly accountable through open meeting laws and solicitation of public comments.

### **2. Do the rules for the insurance market outside the exchange complement those inside the exchange to mitigate “adverse selection”?**

*Rationale:* It is essential that the insurance rules are comparable for plans inside and outside the exchanges, thus promoting a level playing field. If plans outside the exchanges can sell products under more favorable terms, those plans can cherry pick the healthiest consumers, with the exchanges ultimately becoming an insurance pool of primarily high-risk individuals. This would result in high and potentially unaffordable insurance premiums for those consumers who need care the most.

### **3. Is the Medicaid program well integrated with the exchange?**

*Rationale:* Under the ACA, all individuals with incomes under 133 percent of the federal poverty level are eligible for coverage under Medicaid. The exchanges are responsible for screening and enrolling eligible people in the program. It will be critical that the exchange is well integrated with the state Medicaid program to ensure seamless enrollment. Further, because many individuals will move between Medicaid and the exchange over time due to fluctuation in income, it is crucial that exchange rules allow for coordination of plans, benefits, and physician networks to ensure continuous coverage.

### **4. Is the exchange structured to emphasize administrative simplicity for consumers?**

*Rationale:* A major goal of the ACA is to make information about insurance more accessible. Consumers must be able to easily access not only information such as premium rates and enrollment forms, but also critical additional information, such as each plan’s benefits, provider networks, appeals processes and consumer satisfaction measures. This information should be available in multiple languages and literacy levels.

### **5. Does the exchange have a continuous and stable source of funding?**

*Rationale:* To facilitate good management and planning, it is important that the exchanges have a predictable and steady source of funding. Otherwise, there is a risk that funding will become vulnerable to the often unpredictable legislative appropriations process. One option is to establish fees on insurers, which should be assessed on plans inside and outside the exchange, so carriers outside the exchange are not afforded an unfair financial advantage that could lead to adverse selection.

### **6. Does the exchange have the authority to be an active purchaser?**

*Rationale:* To best promote high quality care, innovative delivery system reforms, and for slowing the rate of growth of health care costs, exchanges should have the authority to be “active purchasers” when selecting participating health plans, as opposed to being required to allow every health plan that can meet the minimum requirements to participate. With this authority, exchanges could use their considerable market power and certification authority to limit exchange participation only to plans with a high level of quality and/or value when market conditions permit.



Dear Friend,

On behalf of the Minnesota Patient Advocacy Coalition, I have attached three documents composed by coalition members in response to the U.S. Department of Health and Human Services regulations related to the health insurance exchange.

It should be noted that a number of the Coalition's members, such as the American Cancer Society, the American Heart Association, AARP and the American Diabetes Association either already have, or are planning to submit comments directly to HHS before the federal deadline at the end of October. The enclosed documents, however, should serve as guiding principles for what members of the Coalition believe a health insurance exchange should look like.

As you will see, there are a number of reoccurring themes within the attached documents. As an example, members of the Coalition have submitted recommendations regarding the composition of the exchange governance boards. The American Cancer Society Cancer Action Network and the American Heart Association in particular asserted that it is imperative that board members not have a conflict with their business or professional interests. Other stakeholders, including patients and consumers, are best involved through advisory boards. Members of the Coalition also expressed support for a structure where the governance board is held publicly accountable through open meeting laws and solicitation of public comments.

Additionally, members of the Coalition asserted in public testimony that it is essential the insurance rules are comparable for plans inside and outside the exchanges, thus promoting a level playing field. If plans outside the exchanges can sell products under more favorable terms, those plans can cherry pick the healthiest consumers, with the exchanges ultimately becoming an insurance pool of primarily high-risk individuals. This would result in high and potentially unaffordable insurance premiums for those consumers who need care the most.

Members of the Coalition have also expressed support for the provision in 155.210(b)(2) requiring an exchange to include at least two different types of eligible entities in its Navigator program. In its testimony, the American Diabetes Association stated that this provision is important to ensuring Navigator programs meet the needs of diverse populations, instead of being comprised of just one type of entity that may reach only a narrow segment of the exchange-eligible population. Coalition members have also urged HHS to adopt the proposal under consideration in the preamble to require at least one of the types of entities serving as Navigators in each exchange be a community or consumer-focused non-profit organization.

The Patient Advocacy Coalition appreciates the opportunity to weigh in on the Department of Health and Human Services' recommendations. Additionally, we stand ready to assist the Minnesota Departments of Commerce, Health and Human Services in developing a health insurance exchange that serves the needs of all patients across our state. Thank you for the opportunity to comment and we look forward to continued communication.

Respectfully,

**Matt Schafer** | Minnesota Government Relations Director  
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September 27, 2011

Mr. Steve Larsen  
Deputy Administrator and Director  
Center for Consumer Information and Insurance Oversight  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9989-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

Dear Director Larsen,

On behalf of the nearly 26 million Americans with diabetes and the 79 million more with prediabetes, the American Diabetes Association (Association) appreciates the opportunity to submit comments on the Notice of Proposed Rulemaking for the Patient Protection and Affordable Care Act: *Establishment of Exchanges and Qualified Health Plans* (CMS-9989-P).

The Centers for Disease Control and Prevention (CDC) estimates that as many as 1 in 3 Americans will have diabetes by 2050, and nearly one in two racial/ethnic minority children born in 2000 will develop diabetes in their lifetime, if current trends continue. The costs associated with diabetes, including diagnosed and undiagnosed diabetes, prediabetes, and gestational diabetes, and their complications, accounted for \$218 billion in direct and indirect costs in 2007 alone. Much of the economic burden of diabetes is related to its complications, such as blindness, amputation, kidney failure, heart attack, and stroke. Yet, we have made major strides in effectively managing diabetes and reducing the risk for these devastating – and costly – complications through advances in medical care, medications and other tools, patient self-management, education, and support. Access to affordable, adequate coverage that enables health care access is critically important for people with, and at risk for, diabetes. When people are not able to afford the tools and care necessary to manage their diabetes, they scale back or forego the care they need, which often leads to disabling and costly complications and suffering that could have been prevented.

The Association is hopeful the health insurance Exchanges envisioned under the ACA will provide new, consumer-friendly health insurance marketplaces where people with, and at risk for, diabetes, can access quality health insurance that meets their needs. We anxiously await the proposed federal rule on the Essential Health Benefits, expected later this year, which will be a critical factor in determining whether the Exchanges will provide adequate coverage options for people with, and at risk for, diabetes. How the Exchanges are developed will also be crucial for the success of the new patient protections, including the prohibition on denying coverage or charging a person more because of diabetes. In this spirit, we offer the following comments on the proposed rule.

## **Part 155, Subpart B – General Standards Related to the Establishment of an Exchange by a State**

### **§155.105 Approval of a State Exchange**

We appreciate the emphasis HHS has placed on ensuring all states will have insurance Exchanges operating in time to provide coverage to individuals and small businesses beginning on January 1, 2014. Many individuals with diabetes have been unable to obtain adequate and affordable health insurance coverage in the individual market and the Exchanges will provide a much needed new option for them. We agree that in order to meet the 2014 deadline, an Exchange must be capable of beginning operations to support the initial enrollment period set to begin on October 1, 2013, to meet certain standards, and be able to perform the required functions. As part of ensuring state Exchanges meet the standards on an ongoing basis, HHS should establish a process to accept and resolve consumer complaints at the federal level about the functioning, operations, and/or policies of a state Exchange. The process should ensure HHS reviews consumer complaints and works with states to correct them.

We appreciate states are required to seek stakeholder input during the process of planning for an Exchange. But the public, especially the consumers who will utilize the Exchange, should also have the opportunity to review a state's policy and operational decisions and to comment on them before they are implemented. Therefore, HHS should ensure the public has an opportunity to review and comment on a state's Exchange plan. The final federal rule on Exchanges should also address details of how a federally-facilitated Exchange would work and ensure the federal Exchange's planning document and updates are exposed to public notice and comment.

### **§155.106 Election to Operate an Exchange after 2014**

It is important to establish a process for states to elect to operate an Exchange after 2014, and also to ensure a process is in place if a state operating an Exchange wants to transition to a federally-facilitated Exchange. Key goals should be ensuring as smooth a transition as possible and minimizing disruptions for individuals in the Exchanges. A state electing to begin to operate an Exchange after 2014 should have to include in its plan how it will address changes that may impact consumers and the Exchange operation, including any transition of consumers to new plans and/or changes in benefits as well as changes in website or consumer assistance tools. It is good the proposed rule requires HHS approval or conditional approval of a state Exchange at least 12 months prior to the first effective date of coverage through the Exchange as well as provides a similar time period for transition from a state-operated Exchange to a federally-facilitated Exchange. We also support requiring states to coordinate with HHS on a transition plan. HHS should give further consideration to how it might enforce these provisions and have a backup plan (in the event states do not give at least 12 month notice) that seeks to minimize problems for consumers, particularly avoiding gaps in coverage.

### **§155.110 Entities Eligible to Carry Out Exchange Functions**

An Exchange must remain accountable for meeting all federal and state requirements, even if it delegates specific Exchange functions to outside contractors. We support an ethical, competent, and consumer-centered governance structure for Exchanges. A governing board's specific composition will

shape its priorities, direction, and policies during the formative years of the Exchange and will make decisions directly affecting cost of coverage offered in the Exchange.

We support the requirements that a state must ensure an Exchange that is an independent State agency or a non-profit entity established by the State has in place a clearly-defined governing board administered under a formal, publically-adopted operating charter or by-laws, and holds regular public governing board meetings announced in advance. We are pleased the proposed regulations require Exchanges to implement procedures for disclosure of conflicts of interest by members of the Exchange board or governance structure. We recommend HHS also require all governing bodies to prohibit membership of individuals with a clear conflict of interest, and these individuals should be clearly defined in regulations, such as those with a financial interest in the sale of health insurance, including health insurers and individuals affiliated with health insurers. The preamble states “Exchanges are intended to support consumers, including small businesses, and as such, the majority of the voting members of governing boards should be individuals who represent their interests.” The final regulations should explicitly require consumer and patient participation. We strongly support inclusion of representatives of consumers, and specifically patients, interests on the governing board, and particularly people with expertise in chronic diseases such as diabetes. If HHS ultimately does permit states to decide whether conflicted parties may serve on Exchange boards, boards should be required to have more representation by consumer interests than individuals with conflicts of interest.

#### **§155.130 Stakeholder Consultation**

It will be important for the Exchange to consult with a variety of consumers, employers, patient advocates, and others with specialized knowledge and varied perspectives that can help facilitate enrollment and the seamless operation of the Exchange. Section 1311(d)(6) of the statute lists several stakeholders that must be consulted and CMS proposes expanding this list. It is good the proposed regulations add federally-recognized tribes, public health experts, and health care providers to this list. We recommend Navigators also be added to this list and “educated health care consumers who are enrollees in Qualified Health Plans (QHP’s)” specifically include individuals with chronic disease who have regular and frequent contact with the health care system.

### **Part 155, Subpart C – General Functions of an Exchange**

#### **§155.200 Functions of an Exchange**

We support ensuring all Exchanges perform a minimum set of functions. It is particularly important to consumers that the proposed rule requires Exchanges to perform eligibility determinations across a variety of programs, including the premium tax credits and cost-sharing reductions available through Exchanges, Medicaid, and the Children’s Health Insurance Program. It is appropriate to put Exchanges at the center of a streamlined, coordinated eligibility process. We support the preamble’s statement that the eligibility and enrollment function of the Exchanges should be consumer-oriented and should minimize administrative hurdles and unnecessary paperwork for applicants.

## **§155.205 Required Consumer Assistance Tools and Programs**

Effective, accessible consumer assistance is essential for individuals with ongoing health care needs who are frequent users of the health care system and must clearly understand their coverage options, such as people with diabetes. If consumers cannot navigate the Exchange, either on their own (via the website or kiosks), via Exchange provided “assistors” (call center, etc), or with the help of “outside” assistors, then the Exchange is unlikely to realize its key policy objectives. As such, consumer assistance should be viewed as a core function of Exchanges, deserving of its own standards and accountability measures. State flexibility must be accompanied by a requirement that each Exchange assess the consumer assistance needs in its service area and adhere to measurable, auditable performance standards, and this should be included as part of a state’s Exchange plan.

Subsection 155.205(d) requires an Exchange to have a consumer assistance function. This requirement should lead section 155.205 of the regulation, as the other topics in this section are forms of consumer assistance. We recommend the regulatory language be expanded to more fully describe the complete scope of consumer assistance functions as follows:

(1) Exchanges must include a consumer assistance function that assists consumers, directly or via referral, including, but not limited to, the following areas:

- *Eligibility and application requirements for public coverage programs, eligibility to purchase Qualified Health Plans (QHP), premium tax-credits and cost-sharing reductions, including information about potential end-of-year tax credit reconciliation and potential consumer liability;*
- *How to enroll in or renew coverage, including subsidized and unsubsidized coverage in QHPs and Basic Health Plans (if applicable);*
- *Facilitating applications and providing consumers with a reliable point of contact for assistance throughout the application and plan selection process;*
- *Locating and understanding health plan information such as information on premiums (including applicable tax credit reductions), cost-sharing (including applicable cost-sharing reductions), benefits and coverage limits, QHP quality ratings and transparency of coverage measures;*
- *How to access Exchange, Navigator, health plan, community-based and state government services, including: how to file a complaint; health plan grievances or appeals; tax credit appeals; and, providing referrals for one-on-one counseling as needed;*
- *Assist consumers with issues encountered in using the Exchange website;*
- *Other areas identified as being a significant need, for example, helping consumers understand how COBRA or employer coverage options should be weighed against QHP options;*
- *An ombudsman function, so consumers have a way to resolve Exchange issues that cannot be resolved through other channels.*

### **Call Centers §155.205(a)**

The Exchange call center should serve as a full-function customer service center. The preamble suggests a variety of functions for these call centers—each of these should be codified in regulation. We recommend language be added to paragraph (a) to read as follows:

*An Exchange must provide for the operation of a toll-free call center. The call center must:*

- *Operate both during and outside normal business hours and adjust staff levels in anticipation of periods of higher call volume;*

- *Provide multi-lingual and culturally competent assistance;*
- *Provide assistance to consumers and businesses on a broad range of issues, including but not limited to, the assistance areas listed in (a)(1);*
- *Track and record questions and complaints from callers and make aggregate data publicly available. Use this record to identify and address prominent problems identified by callers;*
- *Track and tabulate call resolution and customer wait times and hang ups. Use this record to identify and achieve customer service goals.*

#### **Internet Website §155.205(b)**

The Exchange website will serve as the main method of using the Exchange for many consumers. We support the recommended data items to be included in the website and suggest augmenting the regulation to include specific goals for usability, accuracy, and timeliness of information. Additionally, the summary of benefits and coverage should be required to be on the Exchange website, and not just available as a link. We recommend paragraph (b) should be expanded to also include:

- *(1)(ix) Provide health plan drug formulary information;*  
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- *(7) Use medical and insurance terms consistent with the Summary of Benefits and Coverage and the glossary of medical and insurance terms;*
- *(8) Collect and publish reports (at least quarterly) that track traffic on the website and assess how well consumers are able to use the site to complete their tasks. More than one tracking method should be employed and included in the report, such as results from a customer feedback survey provided to the consumer as soon as he/she enrolls in coverage on the website, the number of website hits compared with the number of consumers who enroll in coverage, and/or results from consumers through a general feedback feature on the Exchange website.*

#### **Exchange Calculator §155.205(c)**

Given the complexity of determining an individual or family's premium tax credit and cost-sharing reductions, we recommend the federal government provide a consumer-tested, model calculator for use by states. Of particular concern is the potential for required repayment of a portion of the advance tax payments if income is higher than expected. We recommend HHS test model language to inform consumers of this potential liability. The ideal language will fully inform consumers of this potential, without dampening their willingness to purchase coverage.

#### **Outreach and Education §155.205(e)**

Outreach and education will be critical to the success of the Exchange, particularly during the initial enrollment period in late 2013. A lesson from the startup of the Pre-Existing Condition Insurance Plans is that it has taken over a year of continuous outreach to slowly ramp up enrollment. Thus, outreach and education efforts pertaining to coverage available in the Exchanges should begin as early as possible.

To maximize the effectiveness of outreach and education in Exchanges, outreach and education should broadly promote coverage for individuals, families, and small businesses in need of health coverage and care, target specific hard-to-reach populations, and be coordinated among various entities, including Navigators and other state-based and community assistors. Outreach should target all those in need of

coverage. Exchanges should be required to conduct outreach and education activities to target underserved populations and those who experience health disparities due to language barriers, low literacy, race, color, national origin, geography, or disability. States should ensure efforts among all entities conducting outreach and education, including Navigators and other community assistors, are coordinated and convey accessible, accurate, fair and impartial information. Outreach and education efforts should be objectively assessed to ensure these efforts are successfully reaching the full spectrum of eligible consumers.

### **§155.210 Navigator Program Standards**

A robust, impartial Navigator program will be a critical component of Exchange outreach and enrollment. The rule generally requires Exchanges to award grant funds to eligible entities to serve as Navigators, but does not specify a required scope or capacity for each Exchange's Navigator program. We recommend HHS consider whether more specific and measurable Navigator program standards would help ensure Navigators have the capacity to serve broad aspects of the population, including standards requiring the Navigator program to serve clients within a specific amount of time, or standards requiring the Navigator program demonstrate the combination of grantees are conducting outreach activities targeted to each income group, linguistic group, geographical area, and segments of the small business community with high rates of uninsurance. The preamble states an entity need not be able to reach all relevant groups (employers and employees, consumers, including uninsured and underinsured consumers, and self-employed individuals) in order to be a Navigator. We recommend the rule clarify each Exchange's overall Navigator program must have the capacity to serve all of those groups.

We support the provision in 155.210(b)(2) requiring an Exchange to include at least two different types of eligible entities in its Navigator program. This provision is important to ensuring Navigator programs meet the needs of diverse populations, instead of being comprised of just one type of entity that may reach only a narrow segment of the Exchange-eligible population. We urge HHS to adopt the proposal under consideration in the preamble to require at least one of the types of entities serving as Navigators in each Exchange be a community or consumer-focused non-profit organization.

Section 155.210(d)(5) requires Navigators to provide information in a manner appropriate to culturally and linguistically diverse individuals and to individuals with disabilities. Navigator programs should have printed outreach materials available in certain threshold languages based on the service area. Navigator programs must have oral linguistic capacity, including bilingual staff and targeted outreach, and should designate entities to provide language-specific outreach.

We also support the proposal under consideration in the preamble of Section 155.210 to require Exchanges have Navigator programs be operational no later than the first day of the initial open enrollment period.

### **§155.230 – General Standards for Exchange Notices**

We appreciate CMS's recognition in the preamble and proposed regulatory language that applications, forms, and notices must be written in plain language and provide meaningful access to limited English proficient (LEP) individuals and persons with disabilities. It is more critical than ever all written materials

be presented in a manner that will effectively communicate to the wide range of populations affected. To assure all written communications follow the required language standards, we recommend the regulatory language in Section 155.230(b) be expanded to refer to “applications, forms, notices and any other documents sent by an Exchange.”

In the preamble, CMS states there are a number of ways by which an Exchange may provide access to LEP persons or persons with disabilities and offers several suggestions, including information about the availability of oral interpretation services, information about languages in which written materials are available, and the availability of different formats for persons with disabilities. We support inclusion in the final rule of these suggestions to assure effective communication.

Section 155.230(c) requires the Exchange to “reevaluate the appropriateness and usability of [documents] on an annual basis and in consultation with HHS in instances when changes are made.” We recommend a requirement be added that Exchanges provide an opportunity for stakeholders to review notices for readability and accessibility.

The Departments of Health and Human Services, Labor, and Treasury recently published guidance and proposed regulations under the ACA to implement the disclosure for group health plans and health insurance issuers of the summary of benefits and coverage and the uniform glossary. The final regulations should provide that the terms used in all Exchange documents should be consistent with those published by the Departments.

## **Part 155, Subpart K – Exchange Functions: Certification of Qualified Health Plans**

### **§155.1010 Certification Process for QHPs**

The provision of § 155.1010(b) requiring each Exchange to accept multi-State plans (MSPs) as QHPs without applying an additional certification process to such plans raises significant concerns. This could significantly undermine an Exchange’s ability to meet the needs of individuals in each state. In order to effectively serve enrollees and provide a range of attractive, affordable insurance products, many Exchanges may require QHPs to meet additional requirements beyond the minimum requirements delineated in §1311 of the ACA. These could include efforts to have additional certification requirements, benefit standardization, and/or other active purchasing strategies. If MSPs are not required to meet all of the Exchanges’ programmatic and operating requirements, it could undermine their efforts to serve consumers and place other QHPs at a competitive disadvantage. Recognizing the U.S. Office of Personnel Management (OPM) has been given the responsibility for certifying MSPs, we urge you to work with officials at OPM to ensure that MSPs meet not only the minimum federal requirements for the program, but also any additional requirements an Exchange may establish.

### **§155.1020, §156.210 QHP Rate and Benefit Info**

The cost of insurance is a primary concern for people with, and at risk for, diabetes. We support the requirement of §155.1020(c) that QHPs submit rate, benefit, and cost-sharing information to the Exchange at least annually. Detailed information about plan benefits and rates must be collected to determine the plans’ compliance with QHP standards, including adherence to the essential health benefits and actuarial value requirements under Section 1302 of ACA and other standards, such as the

requirement QHPs do not employ benefit designs that have the effect of discouraging enrollment by individuals with significant health needs. To ensure adequate information is collected, “(2) Covered benefits” should be expanded to include specific information about amount, duration and scope of benefits.

### **§155.1040, §156.220 Transparency in Coverage**

The regulation places complementary requirements on Exchanges and QHP issuers regarding the disclosure of key information, in plain language, to Exchanges, HHS, State Insurance Commissioners and the public. We support the codification of the important transparency protections in the proposed rule and believe it will help consumers pick coverage that best meets their needs.

#### **Transparency of Cost-Sharing Information, §155.1040(c)**

HHS should also provide guidance on how an Exchange will monitor compliance regarding whether a QHP issuer has made the amount of enrollee cost sharing under the policy with respect to a specific item or service provided by a participating provider available in a timely manner upon the request of an individual. Exchanges should also clearly state on the Exchange website that consumers can request this information from QHPs and provide appropriate contact information.

#### **Enrollee Cost-Sharing Transparency, §156.220(d)**

This important subsection requires a QHP issuer to make available the amount of enrollee cost sharing under the individual’s plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon request of an individual. Consumers should be able to access information about cost-sharing for a specific item or service without going through a burdensome process. They may want this information while enrolled in a plan prior to scheduling an appointment or filling a prescription, or when comparing plans (for instance, if the consumer needs to use a specific item or service for ongoing daily management of diabetes). In such instances, information made available on the Exchange website may be insufficient and the final rule should ensure consumers can request this information directly from QHPs. HHS should specify QHPs must provide this information free of charge as soon as practicable. The consumer should be able to make this request online and also by phone or other means.

### **Final Considerations**

In addition to providing more explicit federal minimum standards in these proposed rules, we recommend HHS take a similar approach in future Exchange regulations to ensure appropriate baselines are established that all states may exceed, but must not fail to meet. This will be particularly important for the proposed regulations regarding the Essential Health Benefits (EHB), scheduled to be published later this year. The EHB regulations will be critically important to ensuring effective coverage options for consumers inside and outside the Exchanges, including millions of Americans with, and at risk for, diabetes. While the proposed rule on Exchanges does not address the EHB, given the extraordinary burden of diabetes and prediabetes in the U.S., and the availability of effective treatments and therapies, the EHB must ensure adequacy of coverage so people with, and at risk for, diabetes can successfully prevent or manage the disease and its complications. While coverage necessary for people

with diabetes falls across the 10 categories of the EHB included in the ACA, HHS should provide additional guidance to health insurers to ensure people with diabetes are not underinsured.

In conclusion, the Association is hopeful the Exchanges that will be available in every state beginning in 2014 will provide much-needed affordable, quality coverage options that meet the needs of people with, and at risk for, diabetes. In these comments, we addressed some of the areas where we think particular consideration should be given to ensure the Exchanges work for patients, including those with frequent health care needs – such as governance structures, effective consumer assistance tools and programs, and transparency. Of critical importance for people with diabetes seeking health coverage in the Exchanges will be the forthcoming federal regulations on the EHB which will determine the benefits offered by plans inside and outside the Exchanges.

Thank you for the opportunity to comment on the Notice of Proposed Rulemaking for the Patient Protection and Affordable Care Act: *Establishment of Exchanges and Qualified Health Plans*. Should you have any questions, please contact Dr. LaShawn McIver, Managing Director of Public Policy and Strategic Alliances, at (703) 299-5528 or [lmciver@diabetes.org](mailto:lmciver@diabetes.org).

Sincerely,

A handwritten signature in cursive script that reads "Shereen Arent".

Shereen Arent  
Executive Vice President  
Government Affairs & Advocacy  
American Diabetes Association



## **American Heart Association Threshold Questions for State Health Insurance Exchanges**

The Affordable Care Act (ACA) creates state health benefit exchanges that will be the central marketplace for many people to compare and buy insurance plans in the individual or small-group markets. As states consider how to create and implement an exchange, these are the most important questions for them to address.

**1. Is the exchange governance board properly structured to ensure that its decisions serve the best interest of consumers, patients, workers, and small employers?**

*Rationale:* The governance board will make the critical management and policy decisions that determine the direction and success of the exchange. It is important that the members have appropriate management to successfully make the many critical administrative decisions that must be made by 2014. It is imperative that board members not have a conflict with their business or professional interests. Other stakeholders, including patients and consumers, are best involved through advisory boards. Finally, the governance board must be held publicly accountable through open meeting laws and solicitation of public comments.

**2. Do the rules for the insurance market outside the exchange complement those inside the exchange to mitigate “adverse selection”?**

*Rationale:* It is essential that the insurance rules are comparable for plans inside and outside the exchanges, thus promoting a level playing field. If plans outside the exchanges can sell products under more favorable terms, those plans can cherry pick the healthiest consumers, with the exchanges ultimately becoming an insurance pool of primarily high-risk individuals. This would result in high and potentially unaffordable insurance premiums for those consumers who need care the most.

**3. Is the Medicaid program well integrated with the exchange?**

*Rationale:* Under the ACA, all individuals with incomes under 133 percent of the federal poverty level are eligible for coverage under Medicaid. The exchanges are responsible for screening and enrolling eligible people in the program. It will be critical that the exchange is well integrated with the state Medicaid program to ensure seamless enrollment. Further, because many individuals will move between Medicaid and the exchange over time due to fluctuation in income, it is crucial that exchange rules allow for coordination of plans, benefits, and physician networks to ensure continuous coverage.

**4. Is the exchange structured to emphasize administrative simplicity for consumers?**

*Rationale:* A major goal of the ACA is to make information about insurance more accessible. Consumers must be able to easily access not only information such as premium rates and enrollment forms, but also critical additional information, such as each plan’s benefits, provider networks, appeals processes and consumer satisfaction measures. This information should be available in multiple languages and literacy levels.

**5. Does the exchange have a continuous and stable source of funding?**

*Rationale:* To facilitate good management and planning, it is important that the exchanges have a predictable and steady source of funding. Otherwise, there is a risk that funding will become vulnerable to the often unpredictable legislative appropriations process. One option is to establish fees on insurers, which should be assessed on plans inside and outside the exchange, so carriers outside the exchange are not afforded an unfair financial advantage that could lead to adverse selection.

**6. Does the exchange have the authority to be an active purchaser?**

*Rationale:* To best promote high quality care, innovative delivery system reforms, and for slowing the rate of growth of health care costs, exchanges should have the authority to be “active purchasers” when selecting participating health plans, as opposed to being required to allow every health plan that can meet the minimum requirements to participate. With this authority, exchanges could use their considerable market power and certification authority to limit exchange participation only to plans with a high level of quality and/or value when market conditions permit.



Blue Cross and Blue Shield of Minnesota  
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St. Paul, MN 55164-0560  
651 662-8000  
800 382-2000



October 18, 2011

Commissioner Michael Rothman, MN Department of Commerce  
Commissioner Lucinda Jesson, MN Department of Human Services  
Commissioner Edward Ehlinger, MN Department of Health  
State of Minnesota  
St. Paul, MN

Submitted electronically via the [HealthBenefit.Exchange@state.mn.us](mailto:HealthBenefit.Exchange@state.mn.us) email address.

Re: Response to Request for Comment Regarding Proposed Exchange Regulations

Dear Commissioner Rothman, Commissioner Jesson, and Commissioner Ehlinger:

Blue Cross and Blue Shield of Minnesota (Blue Cross) appreciates the opportunity to respond to the Request for Comment Regarding Proposed Exchange Regulations published September 27, 2011. Blue Cross is a non-profit health service corporation that provides coverage to nearly 2.7 million persons. We are the largest health carrier in Minnesota, providing coverage in both the public and private markets.

Blue Cross strongly supports the overall goal of the proposed rules to allow significant deference to state governments. Providing maximum flexibility to the states will ensure that Exchange design is complementary to Minnesota's unique marketplace, which affirms the value of nonprofit health plans and encourages collaboration among stakeholders. Such flexibility is vital to our ability to mitigate adverse selection, leverage existing state regulatory processes to avoid duplicative and conflicting regulation, and maintain affordable coverage options for all purchasers in the private market.

Blue Cross also urges the Departments to explore further opportunities to provide flexibility in related rulemaking while recognizing the implications of a compressed timeframe for establishing Exchanges. The effectiveness of health care reform will require that the federal government, states, health plans and other stakeholders work together in close collaboration. As all parties work to implement changes within a fast-moving regulatory environment, it is critical that we remain cognizant of the practical implications and operational challenges inherent in these proposed rules.

Furthermore, Blue Cross and Blue Shield of Minnesota strongly supports the comments submitted by the Blue Cross and Blue Shield Association on September 28, 2011, to the U.S. Department of Health and Human Services on the Proposed Rule for Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans (CMS-9989-P).

In addition to the general issues addressed above, we offer the following more specific comments for your consideration. Please note that Blue Cross' comments on the proposed rules

[bluecrossmn.com](http://bluecrossmn.com)

are still under development. More specifically, on the Medicaid eligibility proposed rule and the Request for Information regarding a Basic Health Program (BHP), we have identified a number of themes that are reflected in our comments below.

**Ensure affordability for all purchasers by limiting the cost implications of the 90-day grace period (§156.270).**

Blue Cross recognizes the need to promote continuity of coverage and limit churning between commercial coverage and public programs. However, we are concerned that the provision requiring a 90-day grace period after default on premiums will have a negative impact on the affordability of coverage for all individuals.

The proposed July 15<sup>th</sup> regulations prohibit insurers from pending claims past the last paid-to date or from retroactively terminating back to the last paid to date. However well intentioned, this requirement creates a right to four months of coverage for only one month of premium, thus creating an opportunity for gaming of the system. The resulting costs would have to be built into premiums, raising insurance prices for all individuals purchasing in the marketplace. To discourage gaming, Blue Cross is recommending that states are granted the flexibility to allow insurers to pend claims and retroactively terminate to the last paid-to date.

Alternatively, in the event the 90-day grace period requirement remains, Blue Cross recommends that states be allowed to implement protections against the few who may take advantage of this loophole. For instance, a state could require that an individual pay any unpaid premiums prior to enrolling in another qualified health plan (QHP). This would allow a state to protect premium-paying individuals from increased expenses, while holding non-payers accountable.

Furthermore, we recommend that this 90-day grace period remain limited to only those individuals eligible for the premium tax credit. The policy objective behind this provision is to ensure continuity of coverage between commercial coverage and public programs. Limiting this 90-day grace period to subsidy-eligible individuals achieves this policy goal.

Blue Cross shares a commitment to ensuring continuity of affordable coverage for individuals who are unable to pay premiums because of a drop in income. Among the opportunities to promote continuity of coverage is a proactive capability of the Exchange to conduct a redetermination of eligibility for state-funded government programs and real-time enrollment into those programs. This will help to minimize the negative impact to affordability for consumers.

The 90-day grace period serves as a critical example of the imperative to balance policy objectives such as limiting churning with the practical premium impact for all policy holders. A similar challenge was identified in Massachusetts by the actuarial firm Oliver Wyman during that state's implementation of health reform; an analysis suggested that a 400 percent increase in the number of individuals enrolling in coverage for a short-term period and incurring large claims costs ultimately had an impact on premiums for the entire covered population.

**In order to more accurately reflect costs and maintain affordability for the most price sensitive purchasers, the regulations should allow member-level build-up of premiums (§156.265).**

The proposed rule specifically requests comments on whether a member-level build up of premium rates is preferable to a limitation of four rating categories for family composition. Blue Cross strongly supports the ability of health plans to build up rates on a per member basis. This approach more closely follows current practice and more accurately reflects the true costs of coverage, such as family size, age, and smoking status.

A member-level build up would limit the extent to which individuals and smaller families cross-subsidize larger families, at a cost that could be significant if an entire tax household is allowed on a single family contract. Such cross-subsidization would result in higher costs and could discourage coverage take-up rates for individuals and smaller families. A build-up approach ensures that families will pay a premium that is more consistent with their actual cost, which will improve overall take-up of coverage.

Additionally, building up premium rates at the member level would allow for a more accurate method of risk adjustment. Risk adjustment on a member-level basis will better reflect the level of risk and allow for a more equitable administration of risk adjustment.

**Network adequacy standards should reflect state standards of care and maintain the ability of health plans to provide affordable choices for consumers (§156.1050 and §156.230).**

Blue Cross supports the deference that the proposed regulations provides to states for the regulation of network adequacy. We believe that this approach offers the best opportunity to ensure consistent regulation and avoid confusion. Adequate access to necessary providers is best achieved through state network adequacy requirements that reflect state patterns of care and appropriate enforcement mechanisms.

The availability of affordable choices depends on the ability of health plans to offer consumers a choice of different provider networks within an array of QHPs. Networks will become even more critical when the essential benefit set is established, new deductible and out of pocket maximums become effective, and new levels of coverage are in effect. These benefit and cost-sharing changes will limit cost reduction opportunities, leaving network design as a central method for driving value and improving quality. Further limits on network may stifle innovation in the private market and prevent the ability of health plans to reduce health care trend through encouraging the use of high quality, low cost providers – driving value and improved outcomes.

The ability of health plans to drive affordability is already constrained in areas served by a single provider group. The increasing impact of provider consolidation is especially pronounced in smaller communities. In some areas of our state, all doctors and clinics may be affiliated with just one or two large provider organizations. If a health plan is unable to utilize tools that compare providers on their relative costs, quality, and resource use and to align financial incentives for patients to utilize high quality, low cost providers, the ability to offer affordable options, such as the bronze plan, may be limited. Network adequacy requirements, at the federal or state level, should complement growing concerns about provider consolidation with a specific connection to existing legal remedies, if necessary, to address cost implications for consumers.

Overly restrictive network adequacy requirements would limit innovation in the marketplace. In a mandatory coverage environment, we believe consumer choice becomes even more critical to driving value as consumers balance quality providers and plan options, the comprehensiveness of coverage, and the delivery of evidence-based medicine. New and emerging models of care delivery, including accountable care organizations, patient-centered medical homes, and aligned incentive or shared savings contracts, encourage providers to deliver care more efficiently and encourage consumers to spend their health care dollar where it will best meet their needs. Allowing for flexibility in network and benefit design will provide purchasers with the tools for value-driven product choices that place consumers in the best position to manage their own care.

**Implement the essential community provider requirement in a manner that allows health plans to continue to utilize tools to control costs (§156.235).**

Blue Cross recognizes the need to ensure all enrollees have access to necessary provider types. However, it is equally critical to ensure that health plans are permitted to use tools that hold down costs and promote evidence-based medicine. Requiring a health plan to contract with all newly designated federal essential community providers will limit opportunities to drive value and negotiate an affordable reimbursement rate on behalf of our members. Health plans should not be required to contract with essential community providers that do not accept payment rates and contract terms of the issuer because this will impair the opportunity to drive value and clinically based appropriate care, and ultimately impact affordability negatively.

In addition, Blue Cross opposes the creation of an exemption for staff model health plans from the essential community provider requirements as contemplated in the preamble to the proposed rule. Competition on a level playing field should serve as the foundation of the reformed marketplace – both inside and outside of the Exchange – and preferences to particular plan types will limit the ability for true competition based upon price, service and quality.

**Provide state flexibility to develop QHP accreditation and quality reporting standards that best meet the needs of the unique marketplace (§155.1045 and §156.275).**

Blue Cross supports state flexibility in QHP accreditation and in the development of quality reporting on QHPs within the Exchange. States are best equipped to determine the timelines for accreditation to ensure quality and choice for all consumers.

A state-based approach to accreditation within federal standards to drive quality will ensure that Minnesota remains a leader in health care quality and that our leadership continues to be cultivated through collaboration of key stakeholders across the entire health care spectrum on initiatives for the improvement of health care quality. Through the development of community-based nonprofit organizations, including the Institute for Clinical Systems Improvement (ICSI) and Minnesota Community Measurement (MNCM), Minnesota has improved the quality of value-based health care for all Minnesotans. Additionally, the Minnesota Department of Health has implemented a robust set of standardized quality measures that was created with the goal of increased transparency through a uniform method of quality measurement.

Establishing a new federal standard of quality reporting specifically for Exchanges risks duplication that could stifle collaborative efforts in Minnesota and other states, while state

flexibility would further catalyze work that aligns with existing efforts. In addition, flexibility for states to use existing community-based quality measures that meet federal objectives will allow for consistent treatment both inside and outside of the Exchange.

**Maintain state regulation of marketing standards (§156.225).**

Blue Cross supports the deference given to states on the establishment of marketing requirements for QHPs. Given that QHPs may be sold both inside and outside of the Exchange, this flexibility will allow a state to set marketing requirements that are suitable to the entire private market. As with many provisions that impact the manner in which coverage is offered, we have a strong preference for maintaining our state's leadership, the result of which has led to one of the lowest uninsured rates in the nation.

Additionally, a flexible approach is necessary to complement market transitions, including for example, the ability to provide descriptions of related programs, such as wellness programs or disease management initiatives. These health improvement and chronic care management programs are crucial to efforts to continue to improve health care outcomes and reduce overall costs. Therefore, continuing to provide information to consumers on these opportunities is key to the ability of health plans to compete and offer affordable choices to consumers.

**Minimize administrative costs in the administration of the cost-sharing subsidies (§155.340).**

Blue Cross believes it is imperative that government and the health plan community work together to identify operational challenges likely to result during the transition to the reformed market. Although not fully addressed in the context of these rules, one example of a key operational challenge is the administration of cost-sharing subsidies for eligible individuals, a requirement likely to fall upon the health plans based upon experience with other programs, including the administration of Medicare Part D prescription drug coverage. However, in the commercial marketplace inside the Exchange, plans may have challenges in operationalizing this requirement.

In essence, QHP issuers would be required to administer four different levels of a silver plan: 1) no cost sharing reductions, 2) reductions of cost sharing by one-third, 3) reduction of cost sharing by one-half, and 4) reduction of cost sharing by two-thirds. The potential for significant operational challenges and increased administrative costs is worth noting simply to underscore the interrelated impacts of many reform provisions, and to suggest health plans will require help in meeting those challenges.

**Eliminate any unintended chilling effects on access to coverage by removing the additional tax liability penalty for unforeseen changes in household income or household size (§1.36B-4).**

Blue Cross recognizes the need to minimize costs; however, we have serious concerns that the requirement of reconciliation of the premium tax credit, which may result in additional tax liability for some individuals, will have an adverse impact on access to coverage.

This requirement could have an unintended chilling effect on the number of eligible individuals receiving subsidies for fear of a tax penalty resulting from unforeseen change in circumstances,

such as an unanticipated increase in household income or change in household size. Accordingly, Blue Cross recommends removing the requirement for reconciliation that may require the taxpayer to pay an additional tax penalty.

If the reconciliation requirement remains in the final regulation, Blue Cross recommends adopting a *de minimis* standard to exempt a taxpayer if the advance credit payment for the taxable year that exceeds the taxpayer's premium tax credit is less than a certain dollar amount. A *de minimis* standard would reduce the potential for unintended chilling effects as a result of the reconciliation requirement and also reduce administrative costs when the amount being recovered would be less than the costs to recover the excess advanced credit payment.

**Align Medicaid eligibility changes with similar requirements for Exchanges and Medicare.**

The proposed rule reflects the commitment of CMS to work diligently to coordinate eligibility requirements for Medicaid with those for the Exchange. Still, there are a number of areas in which further alignment would be beneficial. For example, the proposed rule's provisions allowing for state flexibility regarding income eligibility (§435.603(h)) could result in coverage or subsidy gaps if a state chooses to rely on monthly income for purposes of Medicaid eligibility, while advance payments of premium tax credits are based on annual income.

There is also a need for alignment between the Medicaid and Exchange rules, and similar rules for the Medicare program to protect dually eligible individuals from administrative difficulties and coverage gaps. Provisions in both rules addressing qualifying events for special enrollment periods or termination of Medicaid coverage (e.g., changes to the coverage month) should be reviewed to ensure that they do not have an adverse impact on dually eligible individuals.

**Evaluate the impact of population risk profiles on a Basic Health Program (BHP) and the insurance Exchange.**

Individuals with household incomes between 133 and 200 percent of the federal poverty level (FPL) comprise a large portion of the population that would be eligible to receive subsidies through an Exchange. Moreover, the value of cost-sharing subsidies for this population will likely induce a larger portion to enroll in coverage compared to those ineligible for cost-sharing reductions. Differences in the risk profile of this lower-income group may also differ from the profile of those between 201 and 400 percent FPL, with significant implications for stability in the BHP, the Exchange or both. To ensure the viability of the Exchange and any potential BHP, a thorough assessment of the population is essential.

**Minimize the impact of "churning" on enrollees.**

A significant number of individuals will move between Medicaid and the Exchange – and a BHP, if available – due to changes in income over time. Today such transitions (between PMAP and MNCare, for example) take place with minimum disruption for members because they generally remain with the same health plan, as long as the plan participates in both programs in the individual's county of residence. Blue Cross recommends that final rules for Medicaid, Basic Health Programs and Exchanges include provisions that encourage seamlessness as individuals move from program to program. For example, rules could allow individuals to be passively enrolled in another offering from their current health plan, with a provision to opt out. It is important to note that decisions about these issues will require careful consideration in

conjunction with state policies, such as selective contracting in managed care programs. A deliberate approach is critical to provide seamless transitions by ensuring that health plans are able to offer their members coverage in all programs throughout the state of Minnesota.

Blue Cross appreciates your consideration of our comments on the proposed rules for the Establishment of Exchanges and Qualified Health Plans. If you have any questions about this letter or if we can provide further assistance, please contact me at 651.662.8786 or [Scott\\_Keefe@bluecrossmn.com](mailto:Scott_Keefe@bluecrossmn.com).

Sincerely,

A handwritten signature in cursive script that reads "Scott A. Keefe".

Scott Keefe  
Vice President  
Policy and Legislative Affairs





## **Comments Regarding Proposed Rules and Requests for Information Regarding Establishment of a Health Benefit Exchange**

**Care Providers of Minnesota** is a statewide, nonprofit trade association representing over 600 proprietary, nonprofit, and government-owned providers of long-term care services including nursing facilities, senior housing, assisted living, and home- and community-based services. We are submitting these comments on behalf of our membership—the individual businesses as employers. Our membership includes employers who would clearly meet the definition of small group; and those who have more than 100 employees.

Within our service sector, we have a heavy reliance on federal Medicaid and Medicare funding as our primary source of operational revenue. As federal and state government payments to providers have been frozen, or reduced during the past three years, providers of long term care services have made difficult operational choices in order to maintain the service level they are required to provide. Wages for most employees have been frozen; hours have been reduced; and employee benefits have been significantly altered. Because wages and benefits comprise, on average, nearly 70% of operational expenses, this area is hit particularly hard during government budget shortfalls. Nursing facilities in Minnesota are especially impacted by Medicaid changes due to the state’s equal rates law which requires them to only charge privately paying residents at the Medicaid payment level.

Although the past three years have been particularly difficult for long term care providers, the gap between their government payment rates and their costs has been significant for over ten years. In 2008, both workers and providers mentioned low wages and lack of affordable health insurance as the top two barriers to long-term retention of workers. To address the insurance issue, in 2008, as part of Minnesota health reform legislation, the Minnesota Legislature directed the Department of Human Services (DHS) to conduct a study including “recommendations for a rate increase to long-term care employers dedicated to the purchase of employee health insurance in the private market.”

DHS contracted with The Lewin Group (Lewin) and its sub-contractors Ingenix Consulting (IC) and PHI to conduct the legislatively mandated research. In order to complete the work, the contractor collected data from both employers and employees in the long-term care field and used this data to construct a database on workers and their health insurance status. (The final report summary, and details of the study are available online at [http://www.dhs.state.mn.us/main/id\\_005728](http://www.dhs.state.mn.us/main/id_005728).)

According to the analysis completed by Lewin, “the total cost (excluding the employee contribution) of funding health (medical and dental) insurance for Minnesota long-term care workers expected to sign up for insurance offered through their employer ranges from \$17.3 million to \$105.1 million per month, depending upon the benefit plan utilized and the assumption made of the number of workers who enroll. The total cost of the insurance for the midpoint estimate of workers (129,000 with 85,140 eligible for coverage) using the plan recommended by Lewin (Minnesota Advantage) with an average of \$100 deductible and with dental tied to medical insurance is estimated at \$59.5 million per month.” The total cost figure includes both state and federal share if funded through Medical Assistance

Key findings from the survey include:

- ▶ Many long-term care workers in Minnesota do not have private health insurance, primarily because they cannot afford it or they do not work enough hours.
- ▶ 25 percent of all long-term care workers (34% of direct service workers) have been uninsured within the past 12 months.
- ▶ 46 percent of all workers have unpaid medical bills.
- ▶ Coverage rates vary by employment setting and job type:
- ▶ Many workers—especially in home care—do not qualify for employee benefits because they work less than full-time.
  - ▶ Many workers spoke of serious problems related to lack of affordable coverage and expressed support for a state initiative to address the issue.
  - ▶ 81 percent of employers rated lack of health insurance as a “high” or “medium” challenge in retaining workers, second only to low pay (96 percent).

It is important to note that data from this analysis is now three years old, and within those three years there have been either reductions to rates of government reimbursements or frozen rates at a time of increasing fixed expenses. This means the percentages of uninsured and underinsured are low as many providers were forced to reduce staff benefits because of these reductions.

Many long-term care workers, particularly direct service workers, do not qualify for health insurance benefits because they work part-time or irregular hours, particularly those in home care. An increasing number of direct care workers in long-term care have been converted to part-time status due to budgetary reductions. For those remaining on full-time status, the health insurance premiums have increased at a rate far greater than any budget increases, or budget adjustments so our members have adjusted their benefits to either a higher-deductible option, a requirement that employees pay more of their premium, or they have dropped employer contributions entirely. Employees who cannot afford the health insurance premiums, or where there is no employer-sponsored health insurance offered to them anymore either qualify for the MinnesotaCare program, or they rely on coverage from their spouse, or they obtain high deductible personal insurance, or they are uninsured.

As the health benefit exchanges are being developed, it is important to consider the group of employers whose primary source of operational income comes from government programs—Medicare and Medicaid. There is no available source of revenue for long term care providers as employers to either offer an affordable health insurance option or to pay the penalty for their employees who obtain premium assistance credit. Establishing a flexible option where there could be a smaller contribution from the long term care service provider as an employer needs to be considered. Furthermore, the timeframes established for implementation need to take into account employers relying on government funding. State and federal funding is reviewed annually, and we do not know our reimbursement until mid-year, with the actual rate changes taking effect on October 1 of each year. Providers adjust their budgets to reflect these payment changes in the fall of each year, including decisions on employer-based health insurance.

Contact Information:  
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**Establishment of Exchanges and Qualified Health Plans  
Implemented Consistent with Title I of the Patient Protection and Affordable Care Act<sup>1</sup>  
(CMS-9989-P; Proposed Rule)**

**THE FOND DU LAC BAND IS HEREBY SUBMITTING THESE COMMENTS IN RESPONSE TO THE**

The Fond du Lac Band is hereby submitting these comments in response to the Department of Health and Human Services' Proposed Rule, "Establishment of Exchanges and Qualified Health Plans," released July 15, 2011.

The Band has followed the order of sections as presented in the Proposed Rule and referenced the issue identifier, as requested by DHHS.

**PREAMBLE TO PROPOSED RULE**

**SUMMARY**

The breadth and depth of the federal responsibility to American Indian tribes and to American Indian/Alaska Native individuals has been woven into the fabric of health care policy of the United States for decades. The Band expects that the benefits and protections afforded tribes and AI/ANs will neither be neglected nor diminished in the implementation of the Affordable Care Act.

The Band appreciates the need to afford states the opportunity for flexibility in establishing exchanges and qualified health plans consistent with Title I. However, the Band believes that states may not have a full appreciation for the federal identity of I/T/Us and may be unable or unwilling to insist on full compliance with federal law pertaining to Indian health care. Consequently, the Band recommends that federal regulation require that all QHP's offer contracts to all I/T/Us and that those contracts be required to contain the Indian Health Care Addendum proposed by the National Indian Health Board and the Tribal Technical Advisory Group to the CMS.

**I. BACKGROUND**

**A. LEGISLATIVE OVERVIEW**

1. Legislative Requirements for Establishing Exchanges

In order to fulfill the obligation for consultation in Section 1321, the Band requests that CMS consult with tribes concerning the development of a federal Exchange(s). The

uncertainty regarding which states will establish Exchanges and how they will address federal Indian law necessitates a concerted effort by CMS to establish Exchanges that satisfy all the requirements of the ACA.

## 2. Legislative Requirements for Related Provisions

The Band requests that CCIIO provide more information to tribes regarding I/T/U and AI/AN provisions in rules that will be proposed in the future. Without more information concerning future direction, the Band finds it difficult to respond adequately at this time. Such information should include a description of future rules and a schedule that identifies dates for publication and comment.

### **B. STAKEHOLDER CONSULTATION AND INPUT**

The Band recognizes the responsibility of all federal agencies and states to consult with tribes in matters that may have an impact on them and urges CMS to inform and monitor and report on state activity concerning consultation with tribes related to the implementation of the ACA.

## **SUBCHAPTER B – REQUIREMENTS RELATING TO HEALTH CARE ACCESS**

### **A. PART 155 – EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE ACA**

#### **SUBPART A – GENERAL PROVISIONS**

#### **155.10 BASIS AND SCOPE.**

#### **155.20 DEFINITIONS.**

#### **SUBPART B – GENERAL STANDARDS RELATED TO THE ESTABLISHMENT OF AN EXCHANGE BY A STATE**

#### **155.100 ESTABLISHMENT OF A STATE EXCHANGE.**

The Band strongly endorses the intent of Section 1311(d)(6) of the Affordable Care Act that requires Exchanges to consult with certain groups of stakeholders as they establish their programs and throughout ongoing operations. The Band believes that states should be mandated to develop a Tribal consultation policy that is to be approved by the State, the Exchange, and Tribes. States must be directed to honor the government-to-government nature of their relationship to tribes and not delegate their responsibilities to consult with tribes to subordinate agencies established to simply operate their exchanges.

### **155.105 APPROVAL OF A STATE EXCHANGE.**

The requirement of adequate consultation with tribes needs to be added to this section. Including critical AI/AN and I/T/U provisions in the “readiness assessment” of the state planning and establishment grants will help ensure that important issues aren’t neglected. At a minimum these provisions would include matters related to waiving cost sharing for American Indians, identifying AI/ANs, QHP contracting requirements, and consultation requirements.

### **155.110 ENTITIES ELIGIBLE TO CARRY OUT EXCHANGE FUNCTIONS.**

This section must include recognition of the sovereignty of tribal governments and the federal character I/T/U operating units have in providing health care to AI/ANs. Just as the federal and state governments play multifaceted roles in regulating, purchasing, and providing care to its employees and citizens, tribes have a wide, however more personal, range of responsibilities to its members. Tribes must not be penalized for the appearance of conflicts of interest and they must be eligible for contracting all operations of exchanges that may be contracted to non-profit organizations.

### **155.120 NON-INTERFERENCE WITH FEDERAL LAW AND NON-DISCRIMINATION STANDARDS.**

Here again, previous federal law and Supreme Court cases have identified the critical distinctions between AI/ANs and other groups. In keeping with these laws and decisions, exchanges must find ways to honor these distinctions. The Band believes that requiring the “Indian Health Care Addendum” will help states avoid costly mistakes as they establish their exchanges. Moreover, in order to address specific AI/AN provisions, it will be incumbent upon states to create special outreach, marketing, and enrollment efforts for this unique population.

### **155.130 STAKEHOLDER CONSULTATION**

The Band agrees with the Department that tribes must be considered stakeholders in the consultation process. Additional consultation responsibilities are identified in previous comments.

## **SUBPART C – GENERAL FUNCTIONS OF AN EXCHANGE**

### **155.205 REQUIRED CONSUMER ASSISTANCE TOOLS AND PROGRAMS OF AN EXCHANGE.**

Section 155.205 (a) Call center. The Band is concerned that in states where county employees carry out outreach and enrollment assistance for clients, the special benefits and protections intended for American Indians will get lost or neglected. States must ensure that call center employees understand special benefits and protections for AI/ANs and I/T/U providers and that they are able to clearly communicate these to AI/ANs.

Section 155.205 (b) Internet Website. The website should make it easy for AI/AN to find out whether I/T/U providers are included in QHPs. Furthermore, all providers – medical and pharmaceutical -- must be able to identify a patient as an AI/AN who is eligible for the waiver of cost-sharing by ACA Sec. 1402(d).

Section 155.205 ( c) Exchange calculator. Rules governing AI/AN cost sharing are different from other populations. The website should identify AI/AN who qualify for waiver of cost sharing and the calculations should reflect this protection.

Section 155.205 (c)(4) Contact information. Contact information on the website should include consumer assistance service offered by the I/T/U. We support the idea that information can be saved by people who are assisting in the enrollment process. However, we are concerned that this could lead to duplication of efforts and unscrupulous practices by those who profit from their role as Navigators.

Section 155.205 (d) Consumer assistance. The Band is concerned that in states where county employees carry out outreach and enrollment assistance for clients, the special benefits and protections intended for American Indians will get lost or neglected. States must ensure that call center employees understand special benefits and protections for AI/ANs and I/T/U providers and that they are able to clearly communicate these to AI/ANs.

We found that having government employees empowered to fix system problems specific to AI/AN consumers and Indian Health Providers was of great assistance in the implementation effort of Medicare Part D.

Section 155.205 (e) Outreach and education. Exchanges should work closely with Tribes and the I/T/U to develop outreach and education efforts. Health insurance literacy is low among the general population in the United States, and it is less understood by AI/AN who primarily have relied upon the Federal Indian health system over the years. Explaining how health insurance works should be done within a cultural and historic context, and should acknowledge and explain how the federal trust responsibility and the requirements of Federal Indian laws affect and interact with new laws, rules and policy. The most trusted people to assume this task are people working for Tribes and the I/T/U. An effort conceived and directed from outside the AI/AN community is unlikely to succeed.

#### **155.210 NAVIGATOR PROGRAM STANDARDS.**

The Band is concerned that the proposed regulations for navigator standards may be used to inhibit or deny the potential benefit of navigator services to AI/ANs and I/T/Us providers. Consideration should be given to permitting tribes to authorize/certify navigators that work exclusively with AI/ANs. A standardized certification curriculum should be

established so that all certified navigators are able to appreciate and carry out outreach and education specific to AI/ANs.

For the reasons stated previously, exempting I/T/U employees from scrutiny related to conflicts of interest needs to be reaffirmed in this section.

**155.220 ABILITY OF STATES TO PERMIT AGENTS AND BROKERS TO ASSIST QUALIFIED INDIVIDUALS, QUALIFIED EMPLOYERS OR QUALIFIED EMPLOYEES ENROLLING IN QHPs.**

**155.230 GENERAL STANDARDS FOR EXCHANGE NOTICES.**

The Band has learned through its program of purchasing Part D Insurance for its members, that having an employee of the I/T/U receive and manage notifications and correspondence from a Plan increases the successful participation of AI/ANs. Ensuring that I/T/Us have the regulatory authority to sponsor enrollment in the Exchanges' plans will increase participation of AI/ANs and make their participation less difficult.

**155.240 PAYMENT OF PREMIUMS.**

The Band strongly urges CMS to mandate that both federal and state Exchanges permit I/T/Us to pay QHP premiums on behalf of qualified individuals. Just as Exchanges may accept aggregate payments from employers it must be able to accept payment from I/T/Us they chose to sponsor. Regulators must understand that, as individuals, AI/ANs have little incentive to pay premiums when they consider health care a Treaty Right.

The definition of IHS beneficiaries who qualify for Federal funds to be used to purchase premiums is fairly straight forward. Under Section 402 of the IHCA, "Indian Tribes, tribal organizations and urban Indian organizations" may use Federal funds to purchase health benefits coverage. These Federal funds may be used to purchase coverage for IHS beneficiaries in any manner, including (but not limited to) through a tribally owned or operated health care plan, a State or locally authorized or licensed health care plan, a health insurance provider or managed care organization, a self-insured plan, or a high deductible or health savings account. In addition, Tribes may have other resources that they may choose to use to purchase premiums without regard to those restrictions.

## Request for Comment on Application of Definition of Indian (p.41879)

The Band endorses the position of the NIHB in its comments regarding the ACA submitted to the Department of Health and Human Services regarding the definition of who is an “Indian”.

### **155.260 PRIVACY AND SECURITY OF INFORMATION.**

The Band is concerned that implementing overly complicated means of authentication using procedures dependent upon technology may inhibit many AI/ANs who may lack the required technical skills and/or equipment.

### **155.270 USE OF STANDARDS AND PROTOCOLS FOR ELECTRONIC TRANSACTIONS.**

## **Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans**

### **155.400 ENROLLMENT OF QUALIFIED INDIVIDUALS INTO QHPs.**

The Band is concerned that Exchanges may not be able to produce, monitor, and manage eligibility and enrollment information regarding AI/ANs unless they find ways to include AI/ANs in policy and regulation development.

### **155.405 SINGLE STREAMLINED APPLICATION.**

The Band endorses the use of a single streamlined application to determine eligibility of federal benefits.

### **155.410 INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS.**

The Band has struggled with the limited Part D enrollment period since its inception. A five month enrollment period would appear to be adequate. It will be critical that Exchanges keep I/T/Us informed of their efforts so that I/T/Us can be engaged in marshalling resources that will improve the success of the initial enrollment period.

### **155.420 SPECIAL ENROLLMENT PERIODS.**

The Band strongly supports special enrollment periods for AI/ANs. Because many AI/AN families are transient, requiring a waiting period following enrollment into a QHP would exclude many AI/ANs from receiving coverage.

### **155.430 TERMINATION OF COVERAGE.**

### **155.700 STANDARDS FOR THE ESTABLISHMENT OF A SHOP.**

### **155.705 FUNCTIONS OF A SHOP.**

**155.710 ELIGIBILITY STANDARDS FOR SHOP.**

**155.715 ELIGIBILITY DETERMINATION PROCESS FOR SHOP.**

**155.720 ENROLLMENT OF EMPLOYEES INTO QHPs UNDER SHOP.**

**155.725 ENROLLMENT PERIODS UNDER SHOP.**

**155.730 APPLICATION STANDARDS FOR SHOP.**

**155.1000 CERTIFICATION STANDARDS FOR QHPs.**

The Band agrees that QHPs must be certified in order to participate in Exchange plans. Moreover, the Band urges the adoption of certain Indian specific provisions in order to ensure that AI/ANs and I/T/Us will participate. Questions regarding identifying AI/AN members, providing culturally specific outreach and enrollment information and including I/T/Us in their networks must be answered in the certification process.

**155.1010 CERTIFICATION PROCESS FOR QHPs.**

**155.1020 QHP ISSUER RATE AND BENEFIT INFORMATION.**

**155.1040 TRANSPARENCY IN COVERAGE.**

**155.1045 ACCREDITATION TIMELINE.**

**155.1050 ESTABLISHMENT OF EXCHANGE NETWORK ADEQUACY STANDARDS.**

I/T/U providers must be given a meaningful opportunity to be included in all QHPs. If there are AI/ANs enrolled, the QHP must make considerable efforts to contract with available I/T/Us. In more remote locations where few providers are available, plans must contract with I/T/U facilities so that AI/ANs see a value in enrolling.

**155.1055 SERVICE AREA OF A QHP.**

**155.1065 STAND-ALONE DENTAL PLANS.**

**155.1075 RECERTIFICATION OF QHPs.**

**155.1080 DECERTIFICATION OF QHPs.**

**For part 156 of the Proposed Rule -- (p. 41922)**

**B. PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES**

**SUBPART A – GENERAL PROVISIONS**

**156.10 Basis and scope.**

**156.20 Definitions.**

**156.50 Financial support.**

SUBPART C – QUALIFIED HEALTH PLAN MINIMUM CERTIFICATION

**156.200 QHP ISSUER PARTICIPATION STANDARDS.**

**156.210 QHP RATE AND BENEFIT INFORMATION.**

**156.220 TRANSPARENCY IN COVERAGE.**

Section 156.220 (d) Enrollee cost-sharing transparency. Information for consumers must accurately describe the special cost-sharing protections for AI/AN.

**156.225 MARKETING OF QHPs.**

**156.230 NETWORK ADEQUACY STANDARDS.**

Application of and Maintaining Compliance with Section 408 of the Indian Health Care Improvement Act

Including I/T/U providers in Exchange plan networks is required by law. Section 408(a) of the Indian Health Care Improvement Act (IHCIA) requires health care programs that receive Federal funding to accept I/T/U providers. It requires any:

"Federal health care program to accept an entity that is operated by the Service, an Indian Tribe, tribal organization, or urban Indian organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program."<sup>2</sup>

The term "Federal health care program" is defined elsewhere in Section 408 by reference to Section 1128B(f) of the Social Security Act, 42 U.S.C. 1320a-7b(f). The Social Security Act broadly defines "Federal health care program" to include "any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code)." 42 U.S.C. §1320a-7b(f). It also includes "any State health care program, as defined in section 1320a-7(h) of this title." *Id.* Under this broad definition, any "plan or program" which provides health

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<sup>2</sup> We note that Section 408(a)(2) of the IHCIA makes it clear that any licensing requirement imposed by a state will be deemed to have been met by the I/T/U provider if it meets the standards required for licensing regardless of whether a license is obtained, and Section 221 of the IHCIA provides that licensed professionals at an I/T/U facility do not have to be licensed in the state in which they are located provided they are licensed in any state.

benefits "through insurance or otherwise" that is funded directly "in whole or in part" by the United States must include I/T/U providers.

It is important to insist that if Exchanges use federal money, they must follow federal law. Moreover, including I/T/U providers in Exchange plan networks will increase the participation of AI/ANs in the plans.

### Creation and Use of an "Indian Addendum" to Exchange Contracts

Setting out applicable Federal law in a single comprehensive Indian contract addendum will reduce administrative cost for States, Exchanges, issuers, and I/T/U facilities rather than duplicate this effort in different settings. The requirements to be included in the I/T/U Contract Addendum include:

- A Tribe or IHS may limit who is eligible for services (without imposing limits on those that may serve individuals who are not eligible for IHS services);
- I/T/Us are non-taxable;
- The Federal Tort Claims Act applies to IHS and Tribal programs, and to those urban Indian organizations that have achieved FTCA coverage through PHSA Sec. 224(g)-(n), to eliminate any QHP requirement to carry professional liability insurance or to otherwise indemnify a QHP;
- Employees of the IHS and Tribal programs are not required to hold a license issued by the State in which the program operates as long as they are licensed in any State.<sup>3</sup>
- The IHS and Tribes may exercise Indian Preference in employment decisions per the following authority<sup>4</sup>
- I/T/U health programs are not required to obtain a license from the State as a condition of reimbursement by any Federal health care program so long as the I/T/U meets "generally applicable State or other requirements for participation as a provider of health care services under the program."<sup>5</sup> "A Federal health care program" means "any plan or that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly in whole or in part, by the United States Government," including health insurance programs under chapter 89 of title 5; and any State health care program, which includes Medicaid, and CHP, as

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<sup>3</sup>IHCIA Sec. 221, enacted into law by Sec. 10221 of the ACA.

<sup>4</sup> 25 U.S.C. § 450e(b) and (2) *Morton v. Mancari*.

<sup>5</sup> IHCIA Sec. 408(b)(3), as amended, defines "a Federal health care program" by reference to 42 U.S.C. § 1320a-7b(f), which includes "any plan or that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly in whole or in part, by the United States Government." Sec. 408(b)(3) does not exclude health insurance programs under chapter 89 of title 5. It also includes any State health care program (as defined at 7 U.S.C. § 1320a-7(h), which includes Medicaid and CHP programs, as well as any program receiving funds under certain other provisions of Federal law.

well as any program receiving funds under certain other provisions of Federal law. Thus, a QHP cannot require licensing in the State as a condition for network provider status nor as a condition for payment for services.

- Special disputes resolution process and recognition of governing law;
- Any medical quality assurance requirements must be subject to new IHClA Sec. 805;
- Compliance with ACA Sec. 1402(d)(2) prohibiting assessment of cost-sharing on any AI/AN enrolled in a QHP
- I/T/Us must be permitted to establish their own days/hours of operation so that any different QHP requirements do not impose barriers to participation
- Nothing in a QHP network provider agreement shall constitute a waiver of Federal or tribal sovereign immunity.

This type of Indian Health Addendum has been used with great success for many years in connection with Prescription Drug Program contracts under Medicare Part D. CMS regulations required Part D plans to offer network contracts to I/T/U pharmacies and include an Indian addendum containing those provisions. These Medicare Part D Addenda have proven to be efficient, effective and easy to use for both Part D plan sponsors and Indian health pharmacies. It is now a standard component of the Part D program.

The Band was encouraged to see that the Department has solicited comments on special accommodations that must be made when contracting with Indian health providers, and the Department's request for comments on use of a standardized Indian health provider contract addendum for QHP issuers. We believe that the use of such a contract addendum will reduce costs and ease administrative burdens for issuers and ensure meaningful participation by AI/AN in Exchange plans. Indeed, the use of an Indian contract addendum will be critical to achieve both goals.

This direct approach for the Exchange establishment regulations to require that all I/T/U facilities be offered a contract with an approved Indian health addendum is the only way to assure network sufficiency for AI/AN. Sufficient choice of providers is not defined in the Proposed Rule, but it is recognized in the preamble to the Proposed Rule (76 Fed. Reg. at 41894) that there are several components to this, including geographic accessibility, ensuring that a provider is able to deliver the care needed by the insured, and the ability to offer culturally competent care.

Indian hospitals and clinics are located in some of the most isolated, sparsely populated and poverty-stricken areas of the United States. For many Indian people, these hospitals and clinics are their only source of health care. The Bristol Bay Area Health Corporation, for example, is located 329 air miles from the nearest non-I/T/U facility in Anchorage, Alaska. The only way to ensure a "reasonable proximity of participating providers" is for QHPs to offer to contract with I/T/U providers. Given that these I/T/U providers are often the only provider in the area, it is not sufficient for the Federal government to merely state in the preamble to the rule that an Exchange "may want to

consider" the needs of AI/AN in remote locations. Unless the Federal government mandates that QHPs include I/T/U providers in their networks, the AI/ANs in these areas may have no in network provider at all.

Geography is not the only barrier to care for AI/ANs, however. In many cases, the I/T/U provider is the only facility with the capacity to serve AI/AN in a culturally competent manner even in areas where other providers may be available. Federal health care is a right long held by AI/AN, and many AI/AN simply will not seek health care from any provider other than an I/T/U provider. Whether because of lack of trust, a history of abuse and discrimination, or because I/T/U providers are the only providers able to offer needed services to their AI/AN populations in a culturally appropriate and competent manner, many I/T/Us will not participate in an Exchange plan unless they can use their I/T/U provider.

Inclusion of I/T/U providers in network will also provide benefit the QHP. Under Section 206 of the IHCA, I/T/U providers have a Federal right to receive reimbursement for the services they provide whether they are in-network or not. Under Section 206, I/T/U providers have the right to recover the "reasonable charges billed ... or, if higher, the highest amount [a] third party would pay for care and services furnished by providers other than governmental entities... " The Secretary has the responsibility under the Act to enforce this provision. If I/T/U providers are not included in Exchange plan networks, there may be more expensive transaction costs incurred by both the I/T/U provider and the QHP. Alternatively, if the requirement for I/T/U providers to be reimbursed by health plans is not effectively enforced, then the QHPs may realize a potential windfall by collecting premiums for AI/AN enrollees – most likely paid for with Federal dollars – and not making full payment for the health services their Indian enrollees receive from I/T/U providers.

#### **156.235 ESSENTIAL COMMUNITY PROVIDERS.**

We support the Proposed Rule's definition of essential community provider to include all health care providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Act. This is mandated by Section 1311(c)(1)(C) of the ACA. Section 340B(a)(4) of the PHS Act includes "Federally qualified health care centers," which are defined in Section 1905(l)(2)(B) of the Social Security Act to include both outpatient health programs and facilities operated by Tribes and tribal organizations under the Indian Self-Determination Act or urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act. Accordingly, we believe that tribal outpatient health programs and tribal facilities as well as urban Indian organizations should be specifically referenced in the regulations as "essential community providers" QHPs must include in their provider networks.

We also appreciate the fact that the Department "continues to look at other types of providers that may be considered essential community providers to ensure that we are not

overlooking providers that are critical to the care of the population that is intended to be covered by this provision," and is soliciting comment on the extent to which the definition should include other providers that provide the same services to the same predominantly low-income, medically underserved populations as the providers listed in Section 340B(a)(4) of the PHS Act. 76 Fed. Reg. at 41899. The facilities of the Indian Health Service certainly fit this bill. IHS facilities serve the same populations as tribal facilities and urban Indian organizations, and in many areas of the country where Tribes do not operate facilities under the Indian Self-Determination Act, the IHS facilities are the only facilities serving the AI/AN population. Accordingly, there is no reasoned basis for not including IHS facilities as essential community providers as well.

**156.245 TREATMENT OF DIRECT PRIMARY CARE MEDICAL HOMES.**

**156.250 HEALTH PLAN APPLICATIONS AND NOTICES.**

**156.255 RATING VARIATION.**

**156.260 ENROLLMENT PERIODS FOR QUALIFIED INDIVIDUALS.**

**156.265 ENROLLMENT PROCESS FOR QUALIFIED INDIVIDUALS.**

Section 156.265 (e) Enrollment information package. In addition to a general information package, it would be helpful for AI/ANs to have a special enclosure that explains their specific benefits and how to access them. It might be confusing to insert this in the publication that goes to the general public. Nothing in the regulations prohibits this.

Section 156.265 (e) Summary of benefits and coverage document. This document should contain specific information for AI/ANs.

**156.270 TERMINATION OF COVERAGE FOR QUALIFIED INDIVIDUALS.**

**156.275 ACCREDITATION OF QHP ISSUERS.**

**156.280 SEGREGATION OF FUNDS FOR ABORTION SERVICES.**

**156.285 ADDITIONAL STANDARDS SPECIFIC TO THE SHOP.**

**156.290 NON-RENEWAL AND DECERTIFICATION OF QHPs.**

**156.295 PRESCRIPTION DRUG DISTRIBUTION AND COST REPORTING.**



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September 28, 2011

Donald M. Berwick, MD  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

RE: CMS-9975-P Patient Protection and Affordable Care Act: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Proposed Rule

Submitted electronically to [www.regulations.gov](http://www.regulations.gov)

Dear Dr. Berwick,

HealthPartners appreciates the opportunity to comment on the Notice of Proposed Rulemaking (NPRM) regarding Standards Related to Reinsurance, Risk Corridors and Risk Adjustment. HealthPartners is the largest consumer-governed, nonprofit health care organization in the nation, providing care, coverage, research and education to improve the health of members, patients and the community. Founded in 1957, the HealthPartners ([www.healthpartners.com](http://www.healthpartners.com)) family of healthcare companies serves more than one million medical and dental health plan members nationwide. HealthPartners family of healthcare organization also employs over 800 physicians, including 300 primary care providers. Through more than 50 medical clinics, 17 dental clinics and 4 hospitals in Minnesota and Western Wisconsin, we provide integrated care delivery and accountable care focused on achieving the Triple Aim- simultaneously optimizing patient experience and the health of the population while keeping costs affordable.

In framing our responses to this proposed rule, it is important to recognize the key features of the Minnesota health care and coverage market that make it unique and that inform our comments. First, Minnesota has the nation's largest and most effective high risk pool for those unable to get coverage – the Minnesota Comprehensive Health Association. This organization, funded in part by contributions from Minnesota health plans, provides coverage to about 27,000 Minnesotans. This presents special opportunities and challenges to the Minnesota market as we need to take into account the impact of this population in the new 2014 market. Second, Minnesota has an uninsured rate significantly below the national average. This puts us in a unique position vis-à-vis using national averages for any calculations. Finally, Minnesota is at the forefront of quality measurement, health improvement and focus on the Triple Aim. We have a rich data environment with which we work regularly. We are a market dominated by vertically integrated care delivery systems. All of this makes Minnesota a very different market from a risk perspective. All of these features drive us to strongly encourage HHS to be **flexible in its approaches** to these key programs designed to manage adverse selection and to **allow for state specific solutions wherever feasible**.

We have specific comments on several provisions, outlined below.

#### **153.220 - Collection of reinsurance contribution funds**

***Reinsurance: the embedded tax*** - HealthPartners does not support the nationally uniform “reinsurance contribution rate”, as described at 153.220. Our concern is not about the reinsurance

*Our mission is to improve the health of our members, our patients and the community.*

portion of the contribution rate. Rather, our concern is about the embedded tax – the US Treasury contribution - described at 153.220(a)(2). A nationally uniform percentage will produce an inequitable sharing of that tax burden across the country.

The purpose of the reinsurance mechanism is to stabilize the post-2014 individual marketplace. Using that purpose as the guide, the embedded tax burden should be placed upon each state based on the ratio between a) the estimated size of its Individual marketplace compared to b) the estimated size of its non-Individual marketplace. The proposed (national) calculation ignores state-to-state differences in that ratio. Certain states (such as Minnesota) have worked hard to shrink their uninsured populations. A nationally uniform percentage rate is inequitable, producing a tax burden that may be 10% to 20% higher than it could be under a state based calculation.

**We therefore recommend that HHS allow state-specific calculation of the amount of the US Treasury contributions.** We believe that there are credible data sources that can be used for an alternative computation. For example, an Robert Wood Johnson-funded entity, [SHADAC](#), has datasets that could be easily adapted to make the calculation we are suggesting.

We recognize that the simplicity of a nationally uniform percentage is attractive. However, the proposed rules already contemplate (at 153.220(b)(3)) that the percentage rate will not truly be uniform across the country. States are free to “collect more than” the national rate. This means that state-specific percentages must be contemplated in the design. Therefore, if HHS expresses the embedded tax as a state-specific percentage per our suggestion, this will not add any marginal complexity to the system.

### **153.230 – Calculation of reinsurance payments**

#### ***Reinsurance: how to value care***

HealthPartners supports most aspects of the reinsurance payment design, as described at 153.230. We concur that the temporary nature of the reinsurance system is best served by designs that are “administratively and operationally simple”.

However, HHS oversimplified the option they chose among the American Academy of Actuaries’ (AAA) recommendations. The AAA report describes its method #4 as follows:

“Use a pre-set threshold of actual health care costs (i.e., attachment point) *or actual health care utilization priced at a fixed-fee schedule.*” [emphasis added].

In contrast, the NPRM says the attachment point should be “based on medical cost to the health insurance issuer for covered benefits”.

The omitted portion of the AAA recommendation is crucial. We strongly urge HHS to restore the fixed-fee approach as a permitted alternative. The practical effect of restoring that alternative will be that states can use an improved design for their attachment point. Otherwise, we predict that the prices of high unit-price provider will be partially borne by the entire market via reinsurance. This is counter-productive, even in a temporary program of this kind.

Certain states (such as Minnesota) have a data infrastructure that can take advantage of the fixed-fee concept and yet remain “administratively and operationally simple”. **We urge you to restore the AAA alternative in the final rule, by expanding the list of parameters at 153.110(a)(2) to include the fixed fee concept.**

### **153.250 Coordination with high-risk pools**

#### ***Reinsurance: Existing state high risk pools***

HealthPartners concurs with the HHS suggestion (see preamble, C.5) that existing high risk pools “should be considered an individual market plan eligible for reinsurance”. As mentioned above, Minnesota has a large high-risk pool, and that population is characterized by extreme adverse selection. The 2014 market changes will be especially challenging for this population. The pool’s inclusion in the temporary reinsurance program is essential to achieving a smooth transition for the marketplace. HealthPartners believes that, in the absence of special consideration, there will be strong financial incentives to “unwind” these high risk pools too quickly. In order, therefore, to ensure a smooth transition to the 2014 marketplace, **existing high risk pools should definitely be considered individual market plans that are eligible for reinsurance.**

#### **Subpart D – State Standards for Risk Adjustment program**

##### ***Risk Adjustment: Prospective method in 2014***

HealthPartners is appreciative of the distinction drawn between risk adjustment “models” and risk adjustment “methodologies” (see preamble, D.1). Our expectation is that our state will propose an alternative risk adjustment methodology (see preamble, D.4), and we are concerned that the NPRM focuses on retrospective methodologies in the initial years.

Certain states (such as Minnesota) have a data infrastructure that is capable of supporting a prospective methodology immediately (i.e., from 2014 forward) without going through a transition from a retrospective methodology. As noted by HHS in the preamble, states with all-payer claim databases lack data about their uninsured populations. However, HealthPartners believes that this problem can be overcome inexpensively, with a combination of techniques applied to no-data members, including personal risk assessments, the interim use of real-time pharmacy-only data, and advanced demographics.

A transition from a retrospective to a prospective method will be extraordinarily costly, complex, and politically sensitive for a state. When federal supports (grants, etc.) are withdrawn, many states will fail to complete that transition. These states’ methodologies will be inadequate for the long-term viability of the affected markets. **The final regulation should clearly and explicitly authorize data-rich states to operate prospective risk adjustment systems from 2014 onward.**

#### **153.340 Data collection under risk adjustment**

##### ***Risk Adjustment: Data de-identification for consumer privacy***

When data are collected and held by states for risk adjustment purposes pursuant to 153.340, the NPRM does not require the states to hold those data in a de-identified format. De-identification is mentioned only for the transmission of data from states to HHS for recalibration purposes.

HealthPartners believes that HHS should require every state to collect and hold data in a de-identified format without exception. Otherwise, the fifty to sixty unique datasets held by states and territories will pose an unprecedented security risk. The privacy standards proposed in the NPRM, at 45 CFR 164.308 et seq., are suitable for small populations served by specific providers who clearly have a need to know the exact identities of their patients. Those privacy standards are woefully insufficient for a dataset that describes every participant in a state’s Individual and small-employer marketplaces.

Many states will use their new datasets for both risk adjustment and for the transitional reinsurance program. At first blush, it might appear that the reinsurance function would require the data to be fully identifiable. This is emphatically not the case. Similarly, it might appear that various auditing functions (for both risk adjustment and reinsurance) would require the data to be fully identifiable. For the same reasons, this is not the case.

Based on our experience with all-payer claim databases, we are also concerned about how well states perform the de-identification function itself. Unless a state and its vendor use a very strict method for de-identification, it would be relatively easy for a hacker to reverse-engineer the system, and thus re-identify the majority of all patients' data in the datasets. We urge you to require de-identification and to require that the datasets must meet rigorous design standards by which re-identification is avoided.

### **153.350 Risk adjustment data validation standards**

#### ***Risk Adjustment: Depth and breadth of audits***

HealthPartners has many years of experience with risk adjustment via Medicare Advantage, via our state Medicaid programs, and in many commercial applications. We recognize that auditing is a crucial aspect of risk adjustment.

We urge HHS to retain more control over data validation audits than is contemplated in the NPRM at 153.350. The NPRM grants the responsibility for these audits to the states that choose to do risk adjustment themselves, so long as a "statistically valid sample" is examined every year. This standard needs to be strengthened and more carefully defined.

Data validation is one of the instances where centralization as an ongoing federal activity is warranted. These audits are highly technical, and very difficult to design. Recent research has shown that diagnosis codes are less trustworthy than previously thought, and over-coding trends can vary substantially at a sub-state level. This will only be further complicated by an almost simultaneous transition to ICD-10. An individual state will be less capable of restraining these secular trends than will a centralized source of expertise at HHS. Given that states are already required to send copies of datasets to HHS (for recalibration purposes), a centralized federal data validation function is quite practical. We urge you to reflect that view in the final regulation.

### **Additional Risk Mitigation strategy to constrain Adverse Selection**

We urge HHS to put additional temporary constraints on the Exchange-affected markets during the transitional (2014-2016) period. We believe adverse selection is the single largest threat to the viability of the new marketplaces. One avoidable source of adverse selection is the Individual members' ability to move among benefit levels (e.g., from bronze to platinum).

HHS should require states to temporarily limit members' benefit movement during open enrollment periods, so that a member can move up only one benefit level per year. We believe this constraint is permissible under law. The ACA requires strict out-of-pocket maximums for members at all benefit levels, and we would not suggest this constraint if that were not the case.

HealthPartners has a unique perspective on this issue. As the largest consumer-governed health plan in the country, we appreciate the value of creating a "consumer-friendly" environment. At the same time, the increased risk of adverse selection of such open choice would be extremely challenging. In this instance, it threatens the basic viability of the marketplace. A balance must be struck between a specific person's access to a large number of choices and the good of the membership overall. On balance, we believe that HHS should avoid adverse selection as much as possible, by placing reasonable constraints upon the Exchange-affected markets.

We appreciate the opportunity to present our comments on this proposed rule and welcome the opportunity to discuss any of these points in more detail.

October 18, 2011  
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Sincerely,

Donna Zimmerman  
Senior Vice President, Government and Community Relations





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**To:** Interagency Exchange Workgroup - Minnesota Departments of Commerce, Human Services and Health

**From:** Donna Zimmerman, Senior Vice President, Government and Community Relations

**Date:** October 18, 2011

Submitted via email to [HealthBenefit.Exchange@state.mn.us](mailto:HealthBenefit.Exchange@state.mn.us)

Below please find HealthPartners' comments in response to the Request for Comment Regarding Proposed Exchange Regulations issued on September 29, 2011.

Overall, as we work with the various Exchange proposed rules, we have three primary points which are foundational:

- ***Level-playing field***  
For the Exchange marketplace to work effectively for all who participate in it, the Exchange governance body needs to ensure that all Qualified Health Plans (QHPs) – be they local plans, national plans, multi-state plans, regional plans or CO-Ops – operate under the same rules and guidelines. This is critical to having a successful marketplace that provides the best value for consumers.
- ***State Flexibility:*** While some uniformity nationwide is important, states need to have maximum flexibility in designing an Exchange that reflects the unique characteristics of their market. Minnesota has a long history of successful innovation in covering the uninsured and has a range of other reforms under development. The state Exchange environment under federal rules needs to be flexible enough to allow such innovations to continue.
- ***Simplicity and Transparency:*** We strongly encourage that our state exchange start as straightforwardly as possible with robust stakeholder involvement and openness on design. As the state gets experience with the Exchange, new features can be added that enhance the marketplace. However, we recommend starting with core functions on 1/1/2014.

We would also like to take this opportunity to reiterate our support for a nonprofit model of governance for the Exchange, as permitted in the proposed rule, similar to the structure that has governed MCHA. We believe that a not-for-profit structure offers the most advantages for a Minnesota Exchange. Minnesota has a positive track record for health reforms through non-profit structures, such as ICSI and Minnesota Community Measurement. Non-profit governance provides the opportunity to build on those successes.

## **Exchange Rules**

### ***Establishment of Exchanges and Qualified Health Plans.***

We are still in the process of finalizing our comment letter to CMS on the first Exchange Rule – the Establishment of Exchanges and Qualified Health Plans (CMS-9989-P). We will copy you on our response as soon as it is completed.

That letter will touch on the following issues, in addition to those articulated above:

- Individual exchange – aggregation of premium (which we do not support as an Exchange function), 90 day grace period for non-payment (concerns with claims payment vs. pending during that time period)

*Our mission is to improve the health of our members, our patients and the community.*

- SHOP exchange – group size (when a group goes over 50 lives) and employee choices within the exchange
- Rating issues
- Need for further clarification on brokers vs. navigators in and out of the Exchange
- Concerns about applying certification requirements to dental plans in the Exchange
- Ongoing funding of the Exchange and, to the extent that some of that funding comes from plan assessments, the need for that assessment not to be included in the calculation of MLR.

***Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Proposed Rule (CMS-9975-P)***  
Attached to this email is our comment letter in response to this proposed rule.

### ***Basic Health Plan RFI***

As the state prepares to respond to the Basic Health Plan RFI, we have the following observations in response to some of the questions posed in the request.

States need flexibility to design and operate the Basic Health Program according to specific state environments. Minnesota has long had a unique and successful approach to covering those in the income levels envisioned for the Basic Health Plan. How those programs interact with both the Exchange environment and a Basic Health Plan are key considerations. A basic framework that allows for significant state flexibility will be most helpful.

Given what we know or can surmise from proposed rules so far (particularly around eligibility), we encourage the state to examine the Basic Health Program carefully as there may be some good reasons to pursue this option in Minnesota. We see the Basic Health Program as an extension of the Medicaid program – a bridge between Medicaid and the Exchange. It needs to be designed and evaluated in that framework, rather than being put in the context of an Exchange plan. We need to be able to have tailored, select networks as well as payment and benefit designs that meet the needs of the designated population.

### **General Provisions**

*1. What are some of the major factors that States are likely to consider in determining whether to establish a Basic Health Program? Are there additional flexibilities, advantages, costs, savings or challenges for the State and/or consumer that would make this option more or less attractive to States? If so, what are they?*

Among the considerations that states will need to take into account are:

- Financial structure and prospective cost to the state for taking on a Basic Health Plan.
- Any additional requirements regarding program structure, benefits or administration.

Final rules need to be issued in an expedited manner so the state has time to make informed decisions about whether to pursue a Basic Health Plan and, if so, what to do with existing programs that serve the same population. Timeliness of rules is also important for providing sufficient lead time for development of the Program.

*3. What are the challenges and costs associated with managing a Basic Health Program?*

Clearly one of the greatest challenges facing any state will be the state's ability to have in place a fully operational IT infrastructure to support seamless Medicaid/Basic Health Program approach.

*6. What guidance or information would be helpful to States, plans, and other stakeholders as they begin the planning process? What other terms or provisions need additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?*

As mentioned above, states and other stakeholders need federal guidance available as soon as possible. Particularly important will be issues surrounding financing. It will be important to understand how the federal share of total expenditures will be calculated. The determination of this amount, as laid out in the ACA, is particularly complicated in 2014 before States have experience operating Exchanges and yet is clearly central to any assessment of the Basic Health Plan option at the State level. Topics of particular interest include the consequences if projections of the anticipated level of federal funding are incorrect, including the entity or individuals CMS would expect to assume responsibility for covering the shortfall, and the extent to which States will have the opportunity to leverage existing sources of Medicaid funding (e.g., matching funds for Medicaid eligibility systems development and improvement) or Exchange funding (e.g., assistance for eligibility and enrollment systems development) to develop and operate a Basic Health Program.

#### **B. Standard Health Plan Standards and Standard Health Plan Offerors**

*3. What is the expected impact of standard health plans on provider payments and consumer access?*

This depends on the ultimate structure of the program. Currently, MinnesotaCare provider payments follow medical assistance. It is conceivable that the same would be the case for a Basic Health Plan. This is a consideration for providers and for access as the state looks at this option.

#### **C. Contracting Process**

*1. What innovative features should States consider when negotiating through the contracting process with standard health plans to participate in a Basic Health Program?*

We encourage the state to consider allowing all qualified health plans to participate in the Basic Health Plan. There are ways to achieve this even in a competitive bidding environment. More plans participating provide more choices for consumers.

*2. What considerations exist in determining whether to utilize the regional compact authority in Section 1331(c)(3)(B) of the Affordable Care Act? Are States interested in pursuing this approach?*

CMS has raised the potential for utilizing authority for regional compacts in implementing Basic Health Plans. However, CMS' expectations for the interaction of such compacts with the establishment of regional compacts for Exchanges are not clear. In addition, the use of regional compacts for Basic Health Plans raises a variety of operational issues such as how such programs may be administered, how federal subsidies would be calculated, and what the implications would be for Exchange operations. We suggest that the state not encourage CMS to expand on this option until state specific programs are up and running effectively.

#### **D. Coordination with Other State Programs**

*1. What is the expected impact of a Basic Health Program on the Exchange's purchasing power and viability? How might States organize a Basic Health Program with respect to purchasing structure?*

Clearly, if a state establishes a Basic Health Plan that will reduce the number of individuals who would be eligible to enroll in qualified health plans (QHPs) offered in Exchanges. This might make Exchanges less interesting to QHPs due to the decreased potential for enrollment and could also change the health status profile of the pool of individuals enrolling.

April 10, 2011  
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HealthPartners appreciates the opportunity to provide these thoughts to the Departments on the proposed rules and the Basic Health Plan RFI. Please feel free to contact us directly with any follow up questions you may have.

Dear Sir/ Ms:

Thanks for sending the information related to Health Benefits. The information is so voluminous that to reply with intelligent and wise reply would necessitates a study that would rival a 4 credit college course and they could be changed or not accepted. I also may be nearing a decade older and in need of glasses. Best suggestion keep it Simple. Reduce the material and reduce duplication and make it understandable.  
Sincerely ***John Schoenecker***

john schoenecker [johnfly49@yahoo.com]



Dear Ms. Gibson:

We are responding to the Minnesota Departments of Commerce, Human Services and Health request for comments regarding proposed rules that were issued by the U.S. Department of Health and Human Services (HHS) regarding the establishment of a Health Benefit Exchange, in order to inform the Departments' own comments and responses to DHHS.

The Legal Aid Society of Minneapolis, with the help of the Legal Services Advocacy Project, has prepared the attached comments on the HHS proposed rule regarding the Patient Protection and Affordable Care Act's (ACA) establishment of Exchanges and Qualified Health Plans (QHP). We plan to submit comments on the proposed rule regarding the ACA's changes to Medicaid eligibility, but are not prepared to share those comments with the Departments at this time.

If there are any questions regarding our comments, please feel free to contact me.

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We offer comments on the following sections of the regulation:

- § 155.110 – Exchange Governance Board Structure
- § 155.130 – Stakeholder Consultation
- § 155.200 – Functions of an Exchange
- § 155.205 – Required Consumer Assistance Tools
- § 155.210 – Navigator Program Standards
- § 155.230 – General Standards for Exchange Notices
- § 155.405 – Single, Streamlined Application
- § 155.410 – Initial and Annual Open Enrollment Periods
- § 155.420 – Special Enrollment Periods
- § 155.1050 – Establishment of Exchange Network Adequacy Standards

§155.110 – Exchange governance board structure

We support HHS's position to clearly define the structure of the Exchange governing board and to require that all appropriate parties have a place on the board. Transparency and formal operating procedures are necessary to earn the public's confidence in this new marketplace. It is also necessary to ensure that those leading the Exchange are motivated by a commitment to the Exchange and not to personal interest.

We suggest HHS strengthen the language of subsection (3) by requiring that no person with a conflict of interest be allowed to serve on the governing board. Conflict of interest should be defined to include anyone who receives direct or indirect remuneration from a health insurance issuer including but not limited to employees and board members, brokers, agents, and those licensed to sell insurance.

The experience listed in the current language of subsection (4) is good but fails to include the critical need of understanding the people who will be customers of the exchange. To insure that the needs, challenges and expectations of the customers is considered in all decision making, we suggest HHS include consumer or consumer representatives with diverse backgrounds reflecting minority and ethnic populations within the state, geographic diversity, age, and gender.

#### §155.130 - Stakeholder consultation

The regulations should specifically require that advocates for persons who need culturally and linguistically appropriate services be included as consumers who must be consulted on a regular basis. The regulation refers to advocates for enrolling hard to reach populations but does not name Limited English Proficiency (LEP) populations as one of these groups. Including this group specifically will give better direction to the administrators of the Exchange regarding needs of this population.

**RECOMMENDATION:** Amend § 155.130(c) to include the following language:

(c) Advocates for enrolling hard to reach populations, which include *individuals for whom English is not their primary language and* individuals with a mental health or substance abuse disorder;

#### §155.200 – Functions of the Exchange

In subsection (d), HHS proposes that an Exchange establish a process for appeals of eligibility determinations. We strongly believe that the appeals process must allow LEP individuals the ability to access and pursue appeals similarly to English speaking applicants. As HHS develops future rulemaking for this subject, we urge HHS to include the requirements that the notices informing applicants of a denial of eligibility must be translated. We recommend a threshold of 500 LEP individuals or 5% of those eligible to be served by an Exchange (e.g. an Exchange's service area), whichever is less. This standard is utilized in the Department of Justice and HHS' LEP Guidances as well as recently revised regulations from the Centers for Medicare & Medicaid Services (CMS) addressing marketing by Medicare Part C & D plans.

We also strongly believe that HHS should require Exchanges to provide taglines in at least 15 languages on all notices, informing LEP enrollees of how to access language services. The request for 15 languages is based on existing government practice. The Social Security Administration, through its Multilanguage Gateway, (<http://www.ssa.gov/multilanguage/>),

translates many of its documents into 15 languages and CMS recently announced plans to translate Medicare forms, including notices, into 15 languages in addition to Spanish (<http://www.cms.gov.EEOInfo/Downloads/AnnualLanguageAccessAssessmentOutcomeReport.pdf>)

Finally, we strongly believe that regardless of whether an Exchange is required to provide written translations of notice, HHS must ensure that oral assistance - through competent interpreters or bilingual staff - is provided to all LEP applicants and enrollees.

#### §155.205 – Consumer assistance tools

The Exchange websites should act as portals for consumers to get all the information they need to select and secure health coverage. Consumers should be able to easily connect with navigators and application assisters through the site. It is not enough for the site to provide general information about Navigators and CAPs. The website should provide accurate and up-to-date contact information.

**RECOMMENDATION:** Amend § 155.205(b)(4) to include the following language:

(4) Provides application with *contact* information for Navigators as described in § 155.210 and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section.

We support HHS's proposal to require Exchange Websites to allow applicants and enrollees to store and access their personal account information and make changes, provided that the Website complied with the standards developed by the Secretary pursuant to § 3021(b)(3) of the PHS Act.

We also support the proposal to encourage Exchanges to develop a feature whereby application assisters are able to maintain records of individuals they have assisted with the application process. This will promote efficiency by utilizing these assisters to inform people of changes in the exchange and timely assistance in recertification.

We fully support HHS' requirement that the Exchange Websites must provide meaningful access to information for LEP individuals. HHS mentions that this may include providing translated information, taglines and/or oral language assistance. This will ensure that Exchanges comply with Title VI and Section 1557. In particular, the Exchange's website should be available in languages in addition to English. Whether the entire portal or only certain vital sections are translated should be determined based on the numbers of LEP individuals eligible to be served by the Exchange and the importance of the information provided. The regulations should specifically require that the tools and programs available to assist consumers be linguistically appropriate:

Require the Exchange Call Center to have ready access to telephonic interpreters who are also trained experts in the program. For oral interpretation services, every person should have access to an interpreter at no cost. The Exchange shall not limit provision of

interpreter services to any specific languages that meet a threshold number of individuals speaking the language in the state.

Require Exchanges to include taglines on the home page of each Exchange website in multiple languages which explain to LEP individuals how to access information that is not translated. This should direct consumers to call the Exchange to access oral communication of the information contained on the website or to access documents the Exchange has translated.

Require that the internet web site list the telephone numbers of language assistance services who can be called to provide interpretation services.

Require that internet web site as well as any outreach and education center translate documents which are considered vital Exchange documents into the major languages spoken in the state. We recommend that HHS adopt a threshold of 500 LEP individuals or 5 % of those eligible to be served by the Exchange, whichever is less.

#### §155.210 – Navigators

##### a. Conflict of Interest

We support HHS's proposal that any entity serving as a Navigator not have a conflict of interest during the term as Navigator. We suggest that HHS define conflict of interest as detailed above under §155.110 – Exchange Governance Board Structure.

##### b. Assure community and consumer-focused nonprofit groups serve as Navigators

We recommend HHS require that at least one of the two types of entities serving as Navigators include community and consumer-focused non-profit organizations. In accordance with the law, Navigators specifically must exhibit qualities and expertise that would allow them to serve uninsured and underinsured consumers well. Trusted non-profit community-based programs can reach and assist low-income and vulnerable individuals and families in a manner appropriate to the community.

In selecting community and consumer-focused non-profit organizations to serve as Navigators, the Exchange should select a sufficient number of entities to adequately serve the entire state. The Exchange should further select a sufficient number and diversity of entities that can meet the needs of all uninsured and underinsured consumers, including organizations with the capability to accomplish Navigator duties in a linguistically and culturally appropriate manner.

**RECOMMENDATION:** Add the following to § 155.210(b)(2)

(2) The Exchange must include entities from at least two of the following categories for receipt of a Navigator grant. ***At least one of the two types of entities serving as Navigators must include community and consumer-focused non-profit organizations.***

c. Culturally and linguistically appropriate

We recommend HHS set forth specific standards Exchanges must implement to assure linguistic and cultural access for persons with limited English proficiency.

Given the Navigator's role in providing linguistically and culturally appropriate information, we recommend the Exchange be required to assess the language needs of all its potential enrollees and award grants to eligible public and private entities based, in part, on this assessment.

We recommend that the Navigator be required to provide competent interpreter services to each LEP person who requests assistance free of charge.

We recommend the Navigator be required to develop and translate vital informational documents into major languages spoken in the state. As noted above, we recommend that HHS adopt a threshold of 500 LEP individuals or 5% of those eligible to be served by the Exchange, whichever is less. Since such translation will take time, we further recommend that any informational documents sent by the Navigator contain a tagline telling the enrollee what telephone number the enrollee can call to receive free translation of the notice or document. The tagline should be translated into the major languages spoken in the state.

We recommend HHS require the Exchange and the Navigator to establish a process for ensuring the quality and accuracy of written materials that have been translated into other languages.

We recommend HHS require the Navigator to develop a community outreach policy to communicate with organizations within LEP communities to provide information to meet the needs of this diverse population.

d. Start-up timeframe

We support HHS's proposal to require that Exchanges ensure that the Navigator program is operational with services available to consumers no later than the first day of the initial open enrollment period. The need for consumer assistance will be greatest as the Exchange is introduced to the market and consumers begin their experience with the Exchange. The public's first impression of the exchange will be lasting; therefore, Navigators must be well-trained and ready to assist consumers through their initial experiences.

155.230 - General standards for Exchange notices

The regulations specify that all applications, forms and notices must be written in plain language and provided in a manner that provides meaningful access to limited English proficient individuals. Providing meaningful notice to limited English proficient individuals means providing notices in an appropriate number of languages.

We recommend HHS require all notices, applications and forms to include a tagline informing that this is important information and that if a person needs this notice translated, call xxx-xxx-xxxx. As noted above, the tagline should be translated into the major languages spoken in the state.

We recommend HHS require all vital documents which include notices and applications to be translated into the major languages spoken in the state. The standard for determining the number of languages should be that 5% or 500 individuals speak the particular language in the state, whichever is less.

#### §155.405 - Single, Streamlined Application

We strongly support HHS' proposal to use a single, streamlined application to determine eligibility and complete enrollment in all affordable health care programs (QHPs, advance payment of premium tax credit, cost-sharing reductions, Medicaid, CHIP, and BHPs) in order to enable applicants to satisfactorily complete the application with a minimum amount of information and number of submissions, while taking into account the characteristics of individuals who qualify for the programs. To that end, the regulations should specify that applicants cannot be required to answer questions not pertinent to the eligibility and enrollment process of those applying for coverage. If additional information is requested, it must be clear that answering additional questions is optional.

In addition to allowing applications to be filed on-line, by telephone, and by mail, the option to apply in person should remain for those who find face-to-face assistance with the application most effective. Applicants and enrollees should be able to submit, change, or renew coverage in all affordable health care programs at places, such as social service offices, welfare offices, and community-based organizations that accept applications for government health benefit programs. However, we strongly support HHS' proposal to apply the coming Medicaid regulation changes doing away with the requirement of a face-to-face interview to all affordable health care programs and permitting electronic, telephonic and facsimile signatures on the streamlined application.

**RECOMMENDATION:** Amend §155.405 as follows:

(b) If the exchange seeks to use an alternative application, such application, as approved by HHS, must request the minimum information necessary to determine eligibility and *only* collect information necessary for enrollment *of those applying for coverage*.

*(1) If additional information is requested, it must be clear that answering additional questions is optional.*

(c) (2) (iv) In person. *An applicant must be able to receive in-person application assistance in any place that accepts applications for government health benefit programs, such as social service offices, welfare offices, and community-based organizations.*

#### §155.410 - Initial and annual open enrollment periods

The proposed rule sets up an extended initial open enrollment period, from October 1, 2013 to February 28, 2014 and HHS seeks comments regarding the length of this initial enrollment period. We support a longer initial enrollment period and echo other commentators' call for an initial enrollment period from October 1, 2013 to March 31, 2014. The additional time will be

helpful to states dealing with an influx of people seeking coverage through exchanges, as well as provide individuals and small businesses adequate opportunity to assess their options to access affordable health care.

We fully support the requirement for exchanges to send written notices to enrollees about annual open enrollment. HHS seeks comments on the proposed codification of the requirement that such notices be sent no later than 30 days before the start of the annual enrollment period. We support the inclusion of the 30 day notice requirement in the final rules. However, the rules should further require the inclusion, at a minimum, of important information about where to get assistance with applying or changing enrollment options, options for coverage, start and end dates of coverage, and the implications of being uninsured.

In subsequent years, HHS proposes setting the annual open enrollment period from October 15 through December 7. We agree with other commentators that the choice of December 7 is arbitrary and not likely to be remembered and would strongly support a uniform 2 month period running from October 15 to December 15 each year. Lengthening the annual open enrollment period will give people more time to apply, enrollees more time to work through options for changing enrollment and the Exchanges more time for processing applications and program selections.

HHS seeks comments regarding whether to require Exchanges to automatically enroll individuals who have received advance payments of the premium tax credits and then are disenrolled from a QHP for any of a number of reasons. We join with other commentators who call for very limited auto-enrollment in order to prevent ‘churning’ or ‘cherry-picking’ of enrollees solely to the benefit of issuers. Exchanges and QHPs should be required to make every effort to provide clear and sufficient notice to individuals about the need to make a QHP selection. QHPs to which enrollees are automatically enrolled by default must have similar provider networks, premiums, and cost-sharing structures to the one in which the individual was initially enrolled. Last, we support strengthening the rule to protect consumers by requiring Exchanges to provide auto-enrolled individuals a 90 day period in which to switch QHPs if they are auto-enrolled in a plan, similar to the Medicaid Managed Care “free look” period.

**RECOMMENDATION:** Amend §155.410 as follows:

(b) *Initial open enrollment period.* The initial open enrollment period begins October 1, 2010 and extends through ***March 31, 2010.***

(d) *Notice of annual open enrollment period.* Starting in 2014, the Exchange must provide advance written notification to each enrollee about annual open enrollment ***no later than 30 days before the start of the annual open enrollment period. Such notice must include, at a minimum, the following information: the date open enrollment begins and ends; language that makes clear that open enrollment is the only opportunity to enroll in new coverage or change coverage; notification of the triggers for special enrollment periods; the penalty for being uninsured; information about any projected changes in premiums or cost-sharing in the enrollee’s current QHP; and where to obtain information about QHPs, premium credits and cost-sharing subsidies.***

*(e) Annual open enrollment period.* For benefit years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through **December 15** of the preceding calendar year.

*(h) Automatic enrollment. Allow auto-enrollment in very limited circumstances and provide individuals who are auto-enrolled a “free look” period that would allow them to change plans without cause.*

#### §155.420 - Special enrollment periods

We support these provisions as a way to ensure continuous coverage when an individual’s circumstances change or the QHP they have chosen cannot adequately cover them, while understanding the need to address the problem of adverse selection. To prevent gaps in coverage or inadequate coverage during a significant change in the individual’s life circumstances, we recommend that the timing of special enrollment periods also allow for the individual to begin the special enrollment period in advance of an anticipated triggering event. Further, HHS should create a temporary or retroactive enrollment process specifically for people losing Medicaid or CHIP coverage so they do not experience a gap in coverage when they move to a QHP for the first time.

HHS proposes granting special enrollment to individuals who gain a dependent through birth or adoption. We strongly support expanding this special enrollment period to pregnant women, as well as permitting an exception to the switching of the level of coverage for pregnant women. Pregnant women may reasonably anticipate that the addition of a dependent will change their eligibility for premium credits, grounds for moving to a different level of coverage as set forth in subdivision (f), and should be in a plan that would provide continuous coverage from pregnancy through the post-partum period.

HHS proposes granting special enrollment to individuals who enroll or fail to enroll in a QHP erroneously only when that error is caused by an error, misrepresentation or inaction of an agent of an Exchange or HHS. We strongly support granting special enrollment to such individuals whether the error was made by the individual alone or an agent of an Exchange or HHS.

#### § 155.1050 - Establishment of Exchange Network Adequacy Standards

- HHS should establish minimum network adequacy standards

The Affordable Care Act (ACA) requires the Secretary of HHS to establish network adequacy requirements for health insurance issuers seeking certification of QHPs. ACA § 1311(c)(1)(B). These proposed regulations would delegate that authority to individual Exchanges, rather than establish a uniform standard. This approach is inconsistent with the ACA, and will lead to undesirable results. As a legal matter, there is no authority in the ACA for delegating the duty to establish network adequacy standards to the Exchanges. In the ACA, Congress clearly mandated the Secretary of HHS to “by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum. . . . ensure a sufficient choice of providers.” ACA § 1311(c)(1). If Congress had wanted each Exchange to develop its own network adequacy standards, it would have said so. It did not, but instead charged the Secretary with establishing minimum standards applicable to all Exchanges.

ACA § 1311(c)(1). The Secretary should not relinquish to the Exchanges her duty to develop network adequacy standards; the result would undermine Congress's intent to subject health plans to uniform standards that apply in all Exchanges, rather than varying standards across the country. Moreover, allowing Exchanges to implement multiple, varying standards will result in complexity that inflates plans administrative costs without improving the quality of care. In addition, the Secretary must ascertain that there are sufficient providers who actually provide all covered services. A standard that merely counts the numbers and types of providers is not sufficient. Ensuring the actual provision of services is especially important for women who may need covered reproductive health services, if some or all of the providers in the area refuse to provide those services. Finally, to the extent that some QHP issuers present health indemnity plans for inclusion in the Exchange, the Secretary should add provisions to require QHPs that are health indemnity plans to demonstrate that they have a sufficient choice of providers accepting their health plan to meet the minimum national network adequacy standards. We recommend that HHS modify these regulations in the final rule to establish minimum network adequacy standards that will apply to all plans in all Exchanges.

**RECOMMENDATION:** Amend § 155.1050 to incorporate language from the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act as follows:

*An Exchange must ensure that the provider network of each QHP ~~is offers a sufficient choice of~~ **in numbers and types of** providers ~~for able to assure that all covered services will be accessible to~~ enrollees **without unreasonable delay. A QHP that is a health indemnity plan shall demonstrate that it offers a sufficient choice of providers accepting its health plan able to assure that all covered services will be accessible to enrollees without unreasonable delay.***

HHS solicited comment on whether it should establish additional minimum qualitative or quantitative standards for the Exchanges to use in evaluating whether QHP provider networks are sufficient. We urge HHS to do so. Network adequacy standards must ensure that the essential health benefits are actually available to QHP enrollees. Without specific minimum standards, enrollees will have little guarantee that they can actually get the services they need. Further, the minimum standards should take into consideration the fact that many religiously-controlled hospitals and clinics may not provide all of the covered services, and individual providers may refuse to offer covered services. These restrictions may limit access to comprehensive reproductive health services and information, as well as end of life care and information about treatment options. An adequate network must include providers that offer all covered services. Moreover, in the event that an enrollee is not able to access the reproductive health services that she needs within the network, in particular due to provider religious or moral objections, the QHP must be required to allow the woman to access services out-of-network without penalty, including in the case of emergencies. Below, we recommend four specific standards that the Secretary should establish as minimum standards for all Exchanges, that would help ensure that enrollees have access to the full range of services they may need.

- (1) HHS should establish criteria to be used by the Exchanges in determining whether QHP's network is sufficient that measure the minimum number of providers to assure that services are accessible.

We recommend that HHS establish specific criteria to measure the number of providers in a network. The goal of such criteria is ensuring that enrollees have meaningful access to the health care services they need. Thus, the metric for determining appropriate numbers of providers must account for the range of services offered by participating providers, and whether providers are accepting new patients. If an enrollee needs contraception, for example, but her plan only offers OB/GYNs who perform pelvic exams and provide prenatal care, the services she needs are not actually accessible to her. Similarly, if an enrollee needs primary care, but his plan does not offer any primary care providers who are accepting new patients, the services he needs are not actually accessible to him. For this reason, as described in greater detail below, HHS should require QHPs to contract with essential community providers for the full range of services they offer, rather than only offering access to certain subsets of services.

HHS should develop criteria to measure the number of providers that account for variation in specialty type and geography, similar to those used in the Medicare Advantage program. After enrollment commences, HHS could update the criteria based on utilization patterns and clinical needs. Such criteria fulfill the goal of assuring that enrollees have access to services, while incorporating flexibility to account for local variation. We recommend that such criteria be developed using the 2011 and 2012 Medicare Advantage Network Adequacy Criteria as a model.

HHS's criteria should account for the needs of special populations who will be purchasing health insurance through Exchanges. These populations include children, people with disabilities, limited English proficient enrollees and women of reproductive age. In addition to the Essential Community Providers described below, QHPs must be required to offer, in addition to the usual range of providers, access to the following providers and services in their networks: interpreters, inpatient and outpatient rehabilitative programs, comprehensive rehabilitative and habilitative services, applied rehabilitative technology programs, wheelchair seating clinics (including access to wheelchair assessments) independent of durable medical equipment providers, specialty care centers (including those Ryan White Care providers serving people living with HIV), Genetically Handicapped Persons Program certified providers, non-coercive reproductive health services, speech pathologists (including those experienced working with nonverbal individuals, persons with developmental disabilities, and persons who need speech generating devices), occupational therapists, orthotics providers and fabricators, physical therapists, case managers for those with significant non-medical barriers to care, and low vision centers. To achieve this goal, we support HHS's comment in the preamble urging Exchanges and Insurance Issuers to define broadly the kinds of providers that can furnish primary care services. Finally, the Exchange should require QHPs to certify that their providers' facilities are accessible to all enrollees, and fully compliant with the Americans with Disabilities Act (ADA).

**RECOMMENDATION:** Add the following language to § 155.1050 (after the language cited above), based on language from 42 CFR § 422.112(a):

*To ensure that the QHP's provider network is sufficient, the Exchange shall ensure that the QHP issuer maintains and monitors a network of appropriate providers*

*that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, ambulatory clinics, home health agencies, and other providers, inclusive of Essential Community Providers.*

- (1) The Exchange shall establish standards to ensure that each QHP that is certified to participate in the Exchange meets the following requirements:
  - (i) QHP shall establish written standards for the number of providers in its provider network that account for the services offered by the providers in its network, and the proportion of providers in its network that are accepting new patients. These written standards must meet or exceed the standards established by HHS.*
  - (ii) The QHP shall establish written standards for its providers that ensure that provider facilities are accessible to people with disabilities and compliant with the Americans with Disabilities Act.**
- (2) HHS should establish criteria to be used by the Exchanges in determining whether a QHP's network is sufficient to ensure reasonable proximity of participating providers to the residence or workplace of enrollees.

We recommend that HHS establish specific criteria to measure the maximum travel time and distance to providers. These criteria should be regularly monitored to assure that enrollees have meaningful access to the health care services they need. HHS can develop criteria to evaluate appropriate travel time and distance that account for variation in specialty type and geography. After enrollment commences, HHS could update the criteria based on the locations of enrollees' homes and workplaces. We recommend that such criteria be developed using the Department of Defense's TRICARE program's access standards. The Special Terms and Conditions of California's 1115 Waiver ¶ 72, which lays out network adequacy requirements for the Medicaid Expansion population under that waiver, could also serve as a model.

**RECOMMENDATION:** Add the following language to § 155.1050 (after the language cited above), based on language from 32 CFR § 422.119(p)(5):

- 3. Under normal circumstances, enrollee travel may not exceed 60 minutes or 30 miles from home or workplace to primary care delivery site. Under normal circumstances, enrollee travel may not exceed 90 minutes or 45 miles from home or workplace to specialty care delivery site.*

HHS also solicited comment on a potential requirement that the Exchange establish specific standards under which QHP issuers would be required to assure that services are accessible without unreasonable delay. It should. To do so, we suggest that the Secretary establish clear timely access standards for primary care, mental health, urgent care, specialty care, and ancillary care appointments. The Secretary should affirm that emergency care must be available to Exchange plan enrollees 24 hours a day, 7 days per week. The Secretary should require Exchanges to certify that participating QHPs meet those standards. We recommend that the

Secretary should look to the timely access standards developed by the Department of Defense for TRICARE Prime as a model for such standards. We also suggest that the Secretary consider ¶72 of the Special Terms and Conditions of California's 1115 Waiver as a model.

**RECOMMENDATION:** Add the following language to § 155.1050 (after the language cited above), based on language from 32 CFR § 422.119(p)(5):

- 4. The wait time for an appointment for a routine, primary care, or mental health care appointment shall not exceed 20 business days; and for an urgent care appointment the wait time shall not exceed 24 hours (or 72 hours if prior authorization is required).*
- 5. The wait-time for an appointment for a specialty visit or ancillary care visit shall not exceed 30 business days.*
- 6. Emergency services shall be available and accessible to handle emergencies (and urgent care visits if not available from other primary care providers pursuant to § 155.1050(c)), within the QHP's service area 24 hours a day, seven days a week.*
- 7. Services under the contract must be made available 24 hours per day, seven days per week when medically necessary.*

- (3) HHS should establish criteria to be used by the Exchanges in determining when an enrollee may access services outside of her QHP's provider network.

We recommend HHS require QHP issuers maintain a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is available in a timely manner. Such a standard is vital to ensuring that enrollees have full access to covered health care services. For example, the incidence of high-risk pregnancies is increasing in the U.S. Women with high-risk pregnancies may need access to specialized services that are not available in the network. Similarly, the ACA contemplates that QHPs may cover abortion services. These services may also not be available from providers in the network, especially for women in medically fragile and/or emergent conditions who may need access to hospital-based abortion care. We suggest that the Secretary establish a standard that would require QHP issuers to maintain a process and criteria for timely evaluation of access to out-of-network providers to obtain covered services without penalty or additional cost to the patient.

- (4) HHS should require the Exchanges to monitor the sufficiency of QHPs' provider networks.

HHS solicited comment as to whether it should require the Exchange establish specific standards requiring QHP issuers to maintain an ongoing monitoring process to ensure that their networks are adequate. HHS must require QHPs to demonstrate adherence to the network adequacy and access standards in an ongoing way in order to continue participating in the Exchanges. While the recertification process will give the Exchange the opportunity to review QHPs compliance with its network adequacy criteria, the Exchange should require the QHPs to monitor compliance more frequently. The Exchange should require the QHP issuers to establish a written process for monitoring each of the criteria used to measure the adequacy of QHP provider networks on a regular basis; taking corrective action if a network falls out of compliance; and reporting such

corrective action to the Exchange. In addition, the Exchanges should require QHP issuers to report any material changes in their QHP provider networks to the Exchanges within 30 days.

Further, the monitoring process used must be transparent, publicly available, and easy for consumers to understand. Information derived through the monitoring process must be broadly disseminated and accessible online and in written form. And, like all information provided in connection with the Exchanges, this information should be conveyed in a manner that is easily understood and accessible to people with low literacy, limited English proficiency, and disabilities.

**RECOMMENDATION:** Add the following language to § 155.1050 (after the language cited above):

*(c) The Exchange shall establish standards to ensure that the QHP issuer shall monitor its QHP provider networks on a continuous basis. The Exchange shall require the QHP issuer to demonstrate, no less than quarterly, that its QHP provider networks comply with the standards set forth in § 155.1050(a) above. In the event of non-compliance, the Exchange shall require the QHP to take corrective action, and to report such corrective action to the Exchange. The Exchange shall also require the QHP issuer to post its quarterly monitoring reports on the Exchange website, and also make them available in hard copy formats. The reports shall be presented in a way that is accessible to people with low literacy, limited English proficiency, and disabilities.*

- ☐ HHS should establish criteria to be used by the Exchanges in determining when alternative standards are necessary to ensure access to all enrollees, including those in medically underserved areas.

HHS solicited comment as to what additional standards might be necessary to ensure that QHPs' provider networks provide sufficient access to enrollees in underserved areas. We suggest that the standards above, taken as a whole, will meet this goal in most instances. We recognize, however, that there may be certain extremely underserved or sparsely populated areas that require alternative minimum standards for travel time and distance. We recommend that the Secretary require the Exchanges to develop criteria to evaluate when an alternative standard is truly warranted. The Secretary should also give the Exchanges guidance as to what alternative standards will be allowed; and require Secretary approval of any proposed alternative standards before they are implemented. Alternative standards should account for circumstances in which enrollees must be able to access services out-of-network as described in subsection d, above. In addition, QHPs that are unable to meet access standards should be encouraged to provide regular scheduled or as-needed transportation from areas within a designated area to network primary care providers, hospitals, and clinics, as necessary to ensure that such facilities remain reasonably accessible. Further, Exchanges should urge these QHPs to dispatch mobile health care vans to locations within the designated area at regular scheduled times, at least quarterly, or more frequently if medically necessary. We suggest that the Secretary refer to the TRICARE access standards, and the 2011 and 2012 Medicare Advantage Network Adequacy Criteria as models.

**RECOMMENDATION:** Add the following language to § 155.1050 (after the language cited above):

- (b) If a QHP demonstrates that it cannot meet the criteria described in section (a)(5), the Exchange shall determine alternative standards for the QHP. Alternative standards must be approved by the Secretary of HHS before they may be implemented. Alternative standards shall be approved when the QHP demonstrates that it cannot meet the criteria described in section (a)(5) above because additional travel is necessary due to the absence of providers (including providers not part of the network) in the area. Prior to approval, the QHP shall submit a detailed access plan that demonstrates that it will provide access to medically necessary services, using methods such as:***
- 1. Providing regular scheduled or as-needed transportation from areas within a designated area to network primary care providers, hospitals, and clinics, as necessary to ensure that such facilities remain reasonably accessible; or***
  - 2. Dispatching mobile health care vans to locations within the designated area at regular scheduled times, at least quarterly, or more frequently if medically necessary.***

September 28, 2011

Department of Health and Human Services  
Center for Medicare and Medicaid Services  
Attention CMS-9989-P  
P.O. Box 8010  
Baltimore, MD 21244-8010  
<http://www.regulations.gov>

**Re: Proposed Rule – Establishment of Exchanges and Qualified Health Plans (CMS-9989-P)**

Dear Madam or Sir:

Thank you for the opportunity to provide comments in response to the Department of Health and Human Services' ("the Department") proposed rule on the Establishment of Exchanges and Qualified Health Plans ("the proposed rule") published July 15, 2011 in the Federal Register. Medica<sup>1</sup> (also referred to as "we" or "our") is an independent and nonprofit health care organization with approximately 1.6 million members, and is Minnesota's second largest nonprofit provider of health insurance and related services. Medica's mission is to work with members and providers to make health care accessible, affordable and a means by which our members improve their health.

Medica fully supports the overarching intent of the proposed rule "to afford States substantial discretion in the design and operation of an Exchange" (FR 41867) and appreciates the way in which the proposed rule attempts to strike a balance between the statutory requirements under the Affordable Care Act ("ACA") and state flexibility. Additionally, we support the proposed rule's goal of "[enhancing] competition in the health insurance market [and improving] choice of affordable health insurance." (FR 41866) Minnesota possesses a unique and innovative health care marketplace. Our objective is for the Exchange to build upon and enhance the existing success of this system. Accordingly, on behalf of Medica, I respectfully submit the following comments to the Department:

***Payment of Premiums (§155.240)***

Medica recommends that the provision in paragraph (d) of §155.240 of the proposed rule allowing the Exchange to facilitate premium payment be removed. Qualified Health Plan ("QHP") issuers already have experience collecting premium payments and will be receiving advanced payments of the premium tax credits and cost-sharing reductions directly from the

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<sup>1</sup> "Medica" refers to the family of businesses that include Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company, Medica Self-Insured and Medica Health Management, LLC, as well as sister organizations Medica Foundation and the Medica Research Institute.



Treasury Department. Therefore, we believe that QHP issuers are in the best position to receive and aggregate individual premium payments from enrollees. If this provision is not removed, then at a minimum, the final rule should specify that individual QHP issuers must retain the option of performing the premium facilitation function themselves.

***Initial and Annual Open Enrollment Periods (§155.410)***

Medica supports the proposal in paragraph (a)(2) of §155.410 of the proposed rule that the Exchange may only permit a qualified individual to enroll in a QHP or an enrollee to change QHPs during the initial open enrollment period, the annual open enrollment period, or a special open enrollment period for which the qualified individual has been determined eligible. We recommend further that it is appropriate to limit an enrollee's plan selection during the annual open enrollment period to up or down one precious metal level (e.g., from a bronze plan to a silver plan but not from a bronze plan to a gold or platinum plan). This approach would minimize the risk to the market of adverse selection by creating a disincentive for enrollees to purchase a QHP with richer benefits only at the point in time in which such benefits are needed. In addition, this approach would create an incentive for a qualified individual to select at the outset the most appropriate plan based on his or her (and any dependents') existing and anticipated future health care needs. It would therefore minimize the number of situations in which an enrollee feels the need to delay necessary care and treatment until he or she is able to "buy up" into a richer QHP – a scenario with significant health and cost implications.

***Employer Choice Requirements in the SHOP (§155.705(b)(3))***

Medica envisions a state-based health Exchange that minimizes disruption to the existing small group market, encourages competition among carriers and maximizes consumer choice. For these reasons, we support the proposed rule's general framework that provides for a flexible, efficient, and consumer-oriented SHOP Exchange. However, we request clarification with respect to the provision in the proposed rule allowing a SHOP Exchange to provide an option to small employers to let their employees choose among QHPs offered in the SHOP by different QHP issuers. In this type of employee choice scenario, the SHOP Exchange is essentially acting as an Individual Exchange with employees making decisions on an individual basis. There is no group purchase. Because the QHP issuer may have only a portion of a group's total employees (e.g., one employee) enrolled in one of its QHPs, the final rule should specify that the QHP issuer is allowed to set premium based on the age, smoking status and geographic location of each individual employee rather than using a composite group rate for each of these factors.

***Risk Pools (§155.705(b)(7)-(8))***

Pursuant to section 1312(c)(3) of the ACA, the proposed rule specifies that a state may either choose to merge the individual market and small group market risk pools within the Exchange, or to maintain separate risk pools. We support this flexibility, recognizing that states will need to undertake a thorough actuarial analysis of the impact of both options on their specific markets before making a final decision.

***Termination of Coverage for Qualified Individuals (§156.270)***

The proposed rule codifies a requirement under Section 1412(c)(2)(B)(iv)(II) the ACA that a QHP issuer provide a 90-day grace period for non-payment of premiums prior to terminating

coverage for an enrollee who is receiving advance payments of the premium tax credit and who have paid at least one month's premium. Medica believes that this provision is in conflict with the objective of the individual mandate provision of the ACA, which is to ensure that every person participating in the health insurance pool contributes their share of premiums in order to help level out costs across the pool. The grace period allows an individual to benefit from four months of coverage but only pay for one of those months, while coverage for the remaining three months is subsidized by other participants. We are particularly concerned about how this scenario has the potential to play out in open enrollment periods – a person may seek coverage, obtain any necessary care or treatment, and then drop coverage after the fourth month. This is concerning not only for the reasons outlined above, but also because it creates an incentive for a person who employs this method repeatedly to forego coverage (and therefore any needed care or treatment) until each annual open enrollment period.

To help mitigate these concerns, we recommend that the final rule permit QHP issuers to pend any claims for services incurred after the premium due date and, upon exhaustion of the 90-day grace period, to retroactively terminate coverage to the date premium was due.

In addition, the final rule should specify that QHP issuers may delay a person's reenrollment into a QHP during a subsequent open enrollment period until any outstanding premiums are paid. (This delay in reenrollment would apply regardless of whether the individual re-enrolled in his or her previous QHP or a different QHP, and the provision should specify that the Exchange would be required to track non-payment of premiums in order to notify a QHP issuer of an applicant's outstanding premium balance with another QHP issuer.)

For the reasons outlined above, Medica does not support the provision in the preamble of the proposed rule (FR 41902) that allows an Exchange to choose to require QHP issuers to provide all enrollees a 90-day grace period, regardless of advance payment status.

Thank you once again for the opportunity to provide these comments. Please do not hesitate to contact me if you have any questions or would like to discuss Medica's comments in more detail. I can be reached directly via telephone at: (952) 992-2461; via email at: [geoffrey.bartsh@medica.com](mailto:geoffrey.bartsh@medica.com); or at the following address: Medica Health Plans, Inc., 401 Carlson Parkway, Mail Route CP250, Minnetonka, MN 55305.

Sincerely,



Geoff Bartsh

Vice President, Public Policy & Government Relations  
Medica





October 18, 2011

**Delivered Electronically via Outlook**

Minnesota Department of Commerce  
Minnesota Department of Human Services  
Minnesota Department of Health  
Saint Paul, MN

**RE: Request for Comment Regarding Proposed Exchange Regulations**

To Whom it May Concern:

Thank you for the opportunity to provide comments regarding the proposed exchange regulations and the Request for Information on establishment of a Basic Health Program. Medica respectfully submits the following comments to the Departments:

Proposed Exchange Regulations

On September 28, 2011, Medica submitted comments to HHS in response to its July 15<sup>th</sup> proposed rule on the establishment of exchanges and qualified health plans. We are including a copy of those comments as a separate attachment in response to this RFC.

Basic Health Plan Request for Information

In determining whether or not the state should establish a Basic Health Program (BHP), we believe the following principles should be given primary consideration: 1) maximizing existing state and federal resources; 2) meeting the needs of the population served through an appropriate benefit set and appropriate cost-sharing; 3) emphasizing a competitive market that preserves choice in health plan coverage; and 4) focusing on the transition between the existing Medicaid program and private market options that would become available to individuals once they leave the BHP.

The MinnesotaCare program has been recognized nationally as a success in providing coverage to low-income Minnesotans. Rather than functioning as a direct alternative to MinnesotaCare, the BHP should be considered as an opportunity to enhance and repurpose MinnesotaCare for a new population and environment. One option may be to merge the existing MinnesotaCare program with a new BHP in such a way that the program could receive federal subsidies while still utilizing state funding sources.



The provider tax has been a significant factor in the success of the MinnesotaCare program because of its broad based application and its sustainability as a funding source for a health care program. As the state considers establishing a BHP it is important to consider the future of the provider tax as a possible funding source. We recognize that the provider tax is currently scheduled to sunset after 2019. If the state pursues the establishment of a BHP it is important that any state funding maintain the same characteristics of the provider tax or that the current sunset on the provider tax is removed.

A BHP that merges components of the existing MinnesotaCare program with a new state plan should incorporate utilization management and benefit features of private coverage while ensuring that the needs of this population are met. In designing an appropriate benefit set, it is important to consider that many enrollees in a BHP will be in transition, (i.e., with incomes too high to be eligible for Medicaid but too low to easily afford private commercial coverage). Therefore, an appropriate benefit set will be one that moves away from a first-dollar coverage model (and the existing \$10,000 cap on inpatient hospital benefits under MinnesotaCare) and toward a higher, more appropriate cost-sharing model within the parameters set forth in section 1331(a)(2) of the ACA. Providing utilization management and financial incentives to promote efficient use of health care services will allow for development of a comprehensive benefit set that provides essential coverage while maintaining affordability.

Since individuals enrolled in plans under the BHP will be transitioning toward the private commercial market, the BHP should mirror this market as much as possible. Therefore, Medica believes that it is important to maintain a strong market component in any BHP so that choice is preserved. Consistent with section 1331(c)(3) of the Affordable Care Act, individuals should have the option of choosing from several plans under the BHP as well as when they leave the BHP to purchase coverage in the private market.

Thank you once again for the opportunity to provide these comments. Please do not hesitate to contact me if you have any questions or would like to discuss Medica's comments in more detail.

Sincerely,



Geoff Bartsh  
Vice President, Public Policy & Government Relations  
Medica

Enclosure

October 18, 2011

To whom it may concern:

The Patient Protection and Affordable Care Act 2010 requires health insurance exchanges to establish a program for awarding grants to “navigators.” These grants are required to come out of the exchange’s operational funds and not from federal funds provided to establish the exchange. Navigators will need to be certified and trained in time for the open enrollment in the fall of 2013 for coverage beginning January 1, 2014.

The Minnesota Health Equity Working Committee would like to stress the importance of both diversity among the navigator pool and the need for demonstrated cultural competence from certified navigators within the system. The ultimate goal of the exchange is to create an even playing field among all populations within Minnesota. This cannot be achieved unless the services provided within the exchange are effectively matched with the populations they seek to serve. The navigators will serve as the conduit for access to all the services within the exchange and the ability of these navigators to deliver within racial and ethnic minority and LGBTQ populations is crucial to the success of the entire exchange.

Also, assuring equal opportunity to become navigators for members from communities most impacted by disparities is necessary as the certification process for navigators is developed. The certification process must consider accessibility in cost, format, language, and means for final assessment for certification. If potential systemic barriers to certification are not mitigated from the beginning, success of the investment in patient navigators will be limited and disparities may be perpetuated.

The Minnesota Health Equity Working Committee is a collaborative of nonprofits, academia, and community leaders from or serving Asian, African, African American, American Indian, Latino, LGBTQ and allied communities. Our mission is to eliminate all health disparities and promote health equity by providing community supported solutions to decision makers and by bringing actionable information back in to the communities, with a vision of an educated and motivated communities fully engaged in decision making, and applying measures and actions that achieve full health equity

Thank you for the opportunity to provide comments regarding the Health Benefits Exchange. We would be happy to provide you greater detail supporting our comments and the important role patient navigators plan in our racial and ethnic minority and LGBTQ communities. You can reach us at [mn.health.equity@gmail.com](mailto:mn.health.equity@gmail.com).

Sincerely,

Minnesota Health Equity Working Committee



October 10, 2011

Dear Commissioners of Commerce, Human Services and Health:

On behalf of NAMI Minnesota (National Alliance on Mental Illness) I am submitting these comments for your consideration as you prepare a response from the State of Minnesota to the federal government regarding proposed rules governing Health Benefit Exchanges. We appreciate the opportunity to provide input.

NAMI would like the rule to contain stronger provisions regarding consumer protection requirements, particularly for determinations on who needs what treatment/services, level of care determinations, lengths of stay, etc. These should be made by treatment professionals who have had face-to-face interviews with the individual. Any medical management tools should be based on research and should be available in a transparent manner. Criteria and reasons for denial of care should be disclosed. We would also like to see guidance in the rule regarding denying claims from criminal justice involved patients who are otherwise eligible to receive services.

Since mental illnesses are cyclical, many people go in and out of the workforce and thus face greater challenges regarding disruption in health care coverage. Every effort should be made to make it easy for people to move between private and public coverage. NAMI would also like to see language that requires states to suspend, not terminate, Medicaid eligibility for people who lose coverage due to being in jail, prison or in an IMD.

Comments to specific sections of the rules are as follows:

- 155.110 Entities to carry out Exchange: NAMI believes it is important that there be individuals on the governing board that have experience and expertise regarding the unique needs of people with chronic health care conditions, disabilities and mental illnesses.
- 155.205 Consumer assistance and tools: Based on our experience last session, it is important that the summary of benefits contains specific information regarding prescription drugs, including links to any drug formularies and clarity regarding coverage of medications that do not yet have a generic equivalent. The outreach and education activities are extremely important, and there should be an extra emphasis on reaching populations that experience health care disparities.
- 155.210 Navigator standards: People with mental illnesses often go back and forth between public and private health insurance programs. It would be helpful, especially if we want to promote employment (which is an evidence-based practice) that entities receiving a navigator grant have benefit specialists who can assist someone to figure out how to work and receive health care benefits. In addition, NAMI would want to ensure that they have knowledge of mental health parity laws. Navigators should have training on how to work with people from diverse backgrounds, including people with mental illnesses.
- 155.420 Special enrollment periods: It is not totally clear if someone can enroll during a special enrollment period if they no longer have coverage, for example, turn 27 and thus must go off of their parent's health plan or are now earning an income so have to go off of Medicaid. With Medicaid being a part of the exchange, we are assuming that the enrollment period does not apply to those programs.

- 155.430 Termination of coverage: QHP's should be required to provide reasonable accommodations to individuals with disabilities, including mental illness, prior to terminating coverage.
- 155.1050 Network adequacy standards: We would like more clarification on "sufficient choice" of providers. It should be more than choice; it should ensure timely access to providers (especially psychiatrists, clinical nurse specialists, psychologists, etc.) within a reasonable distance from work or home. We do not believe that the standards as to what is "sufficient" should be left up to each exchange, but rather, there should be national standards. If there are no providers that can see the individual in a timely manner or within a certain distance than the individual should be able to see an out-of-network provider at no additional cost.
- 156.10 Basis and scope: We are particularly concerned with what will be included in the essential benefit set. For the first time mental health and substance abuse treatment must be covered, and the Wellstone Domenici Parity Act will be applied. Enforcement of this provision, and the essential benefit set, should be a priority under the regulations. It should also be very easy for an individual to find out if a QHIP uses step therapy.
- 156.235 Essential community provider: We support adding community mental health centers to the list of essential community providers. CMHCs serve predominately low-income and uninsured or underinsured people. Most of their funding comes from Medicaid, Medicare, state and county funding. When looking at the long list of who is considered to be an essential community provider (family planning clinics, Ryan White grantees, black lung clinics, etc.) it only makes sense to include CMHCs in this definition.
- 435.116 Pregnant women: Knowing the high rates of postpartum depression in low-income women it would be important to allow continued coverage beyond 60 days for those women who have been diagnosed with postpartum depression.
- 435.118 Infants and children: We are just wondering how the TEFRA program fits into the health exchange. In addition we are wondering if youth aging out of the foster care system will be afforded seamless coverage under the proposed rules.

NAMI hopes that when HHS asks for comments regarding the essential benefit set that you will again reach out to the community for their thoughts. As you might expect, NAMI has a great interest in ensuring that key mental health services are included in the benefit set.

Thank you again for the opportunity to provide comments. Please contact me should you have any questions. .

Sue Abderholden, MPH  
 Executive Director  
 NAMI Minnesota  
 800 Transfer Road, Suite 31  
 St. Paul, MN 55114  
 651-645-2948  
 1-888-NAMI-HELPS  
[www.namihelps.org](http://www.namihelps.org)

Attend the annual NAMI Minnesota state conference *Changing Attitudes, Changing Lives* on November 5th at the Mpls Convention Center. Register at [www.namihelps.org](http://www.namihelps.org)!



# National Indian Health Board



## STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS AND RISK ADJUSTMENT TO BE IMPLEMENTED PURSUANT TO TITLE I OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (CMS-9975-P; PROPOSED RULE)<sup>1</sup>

### ANALYSIS OF PROPOSED RULE BY THE NATIONAL INDIAN HEALTH BOARD<sup>2</sup>

September 27, 2011

The following comments follow the order of sections as presented in the Proposed Rule.<sup>3</sup> These comments supplement comments submitted by the National Indian Health Board (NIHB) to the Center for Consumer Information and Insurance Oversight (CCIIO) of the Centers for Medicare and Medicaid Services, Department of Health and Human Services (HHS) on October 4, 2010.<sup>4</sup>

#### SUMMARY OF COMMENTS

The NIHB concurs in large measure with the approaches taken in the Proposed Rule. In these comments, we highlight those provisions which we view as particularly important to American Indian and Alaska Native (AI/AN) interests. AI/AN will be served by plans offered through the Exchanges, and Tribes and tribal organizations may sponsor Exchange plans,

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<sup>1</sup> Refers collectively to the Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and is used interchangeably with “the Affordable Care Act” or “ACA.”

<sup>2</sup> Established nearly 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area to NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate.

<sup>3</sup> HHS proposes to codify the Proposed Rule by amending 45 CFR subtitle A, subchapter B.

<sup>4</sup> “Comments Regarding 45 CFR Part 170: Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act,” NIHB letter to OCCIIO, October 4, 2010, pages 35 - 37. The agency was previously referred to as the Office of Consumer Information and Insurance Oversight, HHS.



including as CO-OP plan sponsors.<sup>5</sup> We also propose modifications to the Proposed Rule that will ensure that the ACA meets the needs of American Indians and Alaska Natives (AI/AN) and fulfills the federal government's special trust obligations to Tribes. Specifically, we believe the risk management approaches in these regulations are helpful, but not sufficient, to assure access for AI/AN and the inclusion of I/T/U<sup>6</sup> providers in networks. It is vital that other regulations, such as the Proposed Rule on Exchange Establishment (CMS-9989-P), and specifically the provisions pertaining to network adequacy, require qualified health plans offered through an Exchange to offer contracts to I/T/U and do so using an Indian Addendum.<sup>7</sup> Finally, we recommend that HHS include discussion and rulemaking on an additional risk management mechanism that would be specific to AI/AN.

The three programs to be codified in this Proposed Rule are designed to mitigate the potential impact of adverse selection (by making payments to account for higher cost cases) and to stabilize premiums in the individual and small group markets as insurance reforms under the Affordable Care Act are implemented, starting in January 2014. The three risk management mechanisms are reinsurance, risk corridors and risk adjustment. The first two are temporary (3 year) programs; the third program is to be an ongoing risk management mechanism. In these comments, NIHB recommends the inclusion of a fourth mechanism (what NIHB refers to the "HHS Indian Offset") that would provide for making additional risk-related payments to health plans serving AI/AN. Section 1402(d) of the ACA anticipates and authorizes this mechanism.

## DISCUSSION

### **Subpart C – State Standards for the Transitional Reinsurance Program for the Individual Market**

The reinsurance program will make payments to health plans for high-cost cases.

#### § 153.220. Collection of Reinsurance Contribution Funds

HHS included a discussion of two methods for determining contributions to a State's reinsurance pool. Each health insurance issuer and third party administrator, on behalf of a self-insured group health plan, is to contribute to a State reinsurance program. The first method (and the one selected in the Proposed Rule) would establish "a percent of premium amount applied to all contributing entities". The second method (which was rejected in the Proposed Rule) would impose "a flat per capita amount applied to all covered enrollees of contributing entities." All contribution funds collected by a State will stay in that State and

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<sup>5</sup> See NIHB Comments on CMS 9983-P: Establishment of Consumer Operated and Oriented Plan (CO-OP) Program, dated September [14], 2011 and submitted via electronic transmission at <http://www.regulations.gov>

<sup>6</sup> "I/T/U" means the Indian Health Service (IHS), an Indian Tribe, tribal organization or urban Indian organization.

<sup>7</sup> See NIHB comments submitted to the Office of Consumer Information and Insurance Oversight, dated October 4, 2010, submitted via electronic transmission at <http://www.regulations.gov>.

be used to make reinsurance payments on valid claims submitted by reinsurance-eligible plans in that State.

- NIHB concurs with the selection of the “percent of premium” approach. This approach will more likely generate revenues in each State commensurate with the costs and needs in a particular State. The alternative approach could result in excessive revenues being generated in some States and inadequate revenues being generated in other, likely higher cost States.

#### § 153.230. Calculation of Reinsurance Payments

The Proposed Rule identifies two potential approaches to calculating payments to health plans: (1) payment for costs incurred or (2) fixed payment schedule for specific conditions.

- NIHB concurs with the method selected in the Proposed Rule which would use the funds in the reinsurance pool for “payments for costs incurred above an attachment point in order to guard against under serving hard-to-reach high-cost populations in the initial years. By tying payment to actual treatment of the condition, this reinsurance method creates an incentive for plans to provide needed treatments.
- NIHB believes the alternative “fixed payment schedule” method would create an incentive for health plans to enroll AI/AN that have high-cost medical conditions, but would not provide incentives for those plans to actually render timely, quality and comprehensive services to those AI/AN enrollees.

In summary, option 2 (which was rejected under the Proposed Rule) could have created an incentive for enrolling, but not serving, high need, hard-to-reach populations. Option 1, the selected option, in contrast, aligns incentives in a way so that enrollees with high-cost medical conditions and the plan will have the resources and inclinations to seek needed health services (in the case of the enrollee) or provide needed health care (in the case of the providers and health plan).

#### § 153.240. (Timely) Disbursement of Reinsurance Payments

As indicated in the Proposed Rule, the transitional reinsurance program should provide early and prompt payment of reinsurance funds *during* the benefit year. This is particularly important given that the payments under the risk adjustment mechanism and the risk corridors are likely to be calculated *after* the end of the benefit year.

For health plans serving a high percentage of AI/AN, and particularly for smaller plans that may be operated by Tribes, timely payments that counter adverse selection will

be critical not only to the plan's survival but also to ensure that resources for health care services are available when they are needed.

- NIHB concurs with the intention described in the Proposed Rule to provide reinsurance payments during the course of a benefit year and as close as feasible to the submission of verifiable data on the actual claims experience.

#### **Subpart D – State Standards for the Risk Adjustment Program**

The risk adjustment program is intended to provide adequate payments to health insurance issuers that attract high-risk populations by transferring funds from insurers with lower risk enrollees to insurers with higher risk enrollees. The risk adjustment program is intended to reduce or eliminate premium differences between plans based solely on expectations of favorable or unfavorable risk selection or choices by higher risk enrollees in the individual and small group market. The risk adjustment program also serves to level the playing field inside and outside of the Exchange, reducing the potential for excessive premium growth or instability within the Exchange.

##### **§ 153.310 Risk Adjustment Administration: Single Insurance Market**

To avoid and protect against adverse selection, issuers may set premiums higher than necessary in order to offset the potential (but uncertain) expense of high-cost enrollees. Under the Proposed Rule, the evaluation and adjustment for adverse selection is conducted across all plans in the individual and small group markets within a State that are offered inside and outside health insurance exchanges (“Exchanges”). In effect, one risk adjustment pool is operated for an entire State in order to make risk adjustment payments based on a comparison of costs to a State average.

- NIHB concurs with conducting one risk adjustment process in a State that includes all plans in the individual and small group markets that are operating inside or outside one or more Exchanges operating in a State. This approach will reduce gaming by insurers and small businesses that may opt to steer certain (higher cost) enrollees inside an Exchange and other (lower cost) enrollees to non-Exchange plans.

##### **§ 153.310 Risk Adjustment Administration: Statewide Risk Adjustment Pool**

The Proposed Rule aggregates risk pools at the State level, even if a State decides to utilize regional Exchanges. An alternative approach was to aggregate risk pools on a regional basis.

- NIHB concurs with the program design in the Proposed Rule whereby risk is aggregated at the State level, and payments are made from the statewide revenue pool. This approach provides for a broader spreading of risk, is

anticipated to prevent market segmentation by region, and allows for the broadest distribution of risk adjustment payments based on actual resource needs. This approach is more likely to result in resources being available in all corners of a State based upon need rather than reliance on arbitrary geographic boundaries being established that may or may not correlate with need.

§ 153.310 Risk Adjustment Administration: Timing of Risk Adjustment Payments

In the Proposed Rule, comments are requested on the deadline by which risk adjustment payments must be completed.

- NIHB stresses the importance of timely risk adjustment payments. Prompt payment will be particularly critical after the expiration of the reinsurance and risk corridor mechanisms (after year 3). NIHB recognizes that, in the initial years, it will be necessary to develop a baseline data set to calculate risk adjustment payments. For subsequent years, though, NIHB recommends that HHS consider making interim risk adjustment payments to plans based on their prior year plan enrollee demographics.

For health plans serving a higher percentage of high-cost enrollees (some of whom may be AI/AN enrollees) and particularly for smaller plans (some of which may be operated by Tribes), timely payments that compensate for potentially higher cost enrollees will be critical not only to ensure that resources for health care services are available when they are needed but also to ensure that such plans will be able to sustain themselves and survive over time. Again, for plans with a significantly higher risk enrollee population and/or for small plans, the carrying costs of waiting for risk adjustment payments post-benefit year may be substantial.

§ 153.340 Data Collection under Risk Adjustment

The State, or HHS on behalf of the State, must collect risk-related data to determine individual, plan-specific risk scores that form the basis for risk adjustment. Insurers are to submit raw claims and encounter data sets to the State government consistent with to-be-developed national standards for data submission and use. HHS has requested comments on potential alternative uses of the risk adjustment data to support other Exchange-related functions.

- NIHB strongly recommends that the claims and encounter data that are provided to a State or HHS be made available and used to support other Exchange-related functions and broader purposes of the Affordable Care Act. Specifically, NIHB recommends that claims and encounter data be made available to determine the extent to which the plans can accurately classify

claims and encounter data of 1) AI/AN served in fulfillment of federal trust responsibilities and legal obligations to Indians including those who self-identify as AI/AN regardless of any other race or ethnicity they indicate in addition; and 2) the diagnoses, procedures and payments made for any item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

For AI/AN, the claims and encounter data currently made available from the Indian Health Service (IHS), and from the Medicaid program's State Information System (MSIS) and from the Medicare program's enrollment and claims-based data provide a valuable picture of the type, quantity and cost of services rendered to AI/AN. From these data, improvement efforts can be targeted to expand access to health care services, to improve provider billing and plan payment practices, and to identify practices that may be retarding improvements in health status among AI/AN.

These currently available data need to be supplemented by encounter and claims data from private health insurance plans serving AI/AN in order to create a complete and valid picture of the services and expenditures being made on behalf of AI/AN. Providing such data will enable research to determine the adequacy of health services to AI/AN and, at the same time, address a main goal articulated in the Affordable Care Act.

Under section 10221 of the ACA,<sup>8</sup> the law states, "A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States."

The section of the law continues with a "Declaration of National Indian Health Policy," stating that "Congress declares that it is the policy of the Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy"...<sup>9</sup>

Again, the provision of the encounter and claims data from plans subject to the risk adjustment mechanism will greatly contribute to understanding and

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<sup>8</sup> § 102(2) of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (IHCIREA), as reported by the Committee on Indian Affairs of the Senate in December 2009, and included by reference in the ACA at section 10221.

<sup>9</sup> § 103 of the IHCIREA.

addressing the health care needs of AI/AN. Particularly as the data pertain to AI/AN, it is critical that the Federal government establish guidelines for consistent methods and systems to gather and report the data. For instance, how information is gathered on who is an AI/AN can greatly influence the number of individuals ultimately identified in the data systems as being AI/AN. There is also a need to indicate which agency and at what level of government will be responsible for reporting and/or providing access to data on AI/AN persons and I/T/U providers.

NIHB supports maintaining the privacy of individual enrollees. Valid concerns over privacy can be adequately addressed, however, as long as the data are made available in a manner consistent with the to-be-developed standards for medical data submission and use. NIHB does not support the contention that claims and encounter data are “proprietary” and should not be made available for legitimate analytical purposes. NIHB urges the adoption of appropriate data use policies that would allow for accurate assessments of the Affordable Care Act, the Indian Health Service, Medicaid and Medicare and their ability to carry out the “special trust responsibilities and legal obligations [of the Federal government] to Indians.”

#### **Subpart F – Health Insurance Issuer Standards Related to the Temporary Risk Corridor Program**

The risk corridor program is designed to limit the extent of issuer losses and gains.

- The risk corridor program is designed to lessen the extent of significant gains or losses experienced by a health plan as a result of the level of intensity of services to enrollees during the initial years of Exchange establishment. We concur that this program will serve to reduce risk to the Exchange plans, but we believe that this and the two other risk mitigating programs discussed in this Proposed Rule are not sufficient to remove potential financial incentives for health plans to avoid enrollment of AI/AN.<sup>10</sup>

A primary means of depressing enrollment of AI/AN in a health plan is the lack of inclusion of I/T/U providers in the plan’s network. The offering of in-network contracts to all I/T/U providers in a plan’s service area, as we are recommending be required, will serve to (1) broaden the range of health plans selected by AI/AN, thereby spreading any heightened financial exposure more evenly across a broader number of plans, and (2) for AI/AN

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<sup>10</sup> On average, AI/communities suffer from some of the most intense health care conditions when compared to other populations. For specific AI/AN individuals and communities who may or may not have higher-than-average health care costs, this perception has led to a lack of interest by health plans to seek to enroll or proactively serve AI/AN individuals and communities. In addition, during the initial phase-in of the health insurance coverage expansions, there is likely to be pent up demand for health services from uninsured AI/AN.

who enroll in a particular plan they will, at a minimum, be able access their traditional providers of health care services.

Combined with the three ACA-established risk mitigating programs, the mandatory offer of contracts to I/T/U providers will strengthen the financial health of plans who wish to proactively serve AI/AN. Conversely, a requirement to require offers of in-network contracts to I/T/U providers, together with these other risk mitigating measures, will minimize the likelihood a health plan that determines it may be in their interest to (1) avoid enrollment of AI/AN or (2) poorly serve AI/AN who do enroll by excluding the traditional providers to Indian people will reap a financial benefit from doing so. At a minimum, the AI/AN enrollees in the health plan would be able to access their I/T/U providers,

### **Additional Mechanism to Protect Plans and Enrollees from Adverse Selection: “HHS Indian Offset”**

NIHB encourages HHS to include an additional risk management mechanism in the Proposed Rule that would, like risk adjustment, risk corridor and reinsurance, “mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the Exchanges are implemented.”<sup>11</sup>

Under “Special Rules for Indians” in section 1402(d) of the Affordable Care Act,<sup>12</sup> AI/AN with family income at or below 300 percent of the federal poverty line who are enrolled in the individual market in an Exchange are protected from any cost-sharing requirements. In addition, any AI/AN (regardless of income) enrolled in a qualified health

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<sup>11</sup> Contained in the “Summary” statement of the Proposed Rule, Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, *Federal Register*, Vol. 76, No. 136, Friday, July 15, 2011, page 41930.

<sup>12</sup> ACA section 1402(d) reads as follows: *(d) SPECIAL RULES FOR INDIANS.—*  
*(1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—(A) such individual shall be treated as an eligible insured; and (B) the issuer of the plan shall eliminate any cost sharing under the plan. (2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services— (A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and (B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A). (3) PAYMENT.—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.*

plan in an Exchange shall not have cost-sharing requirements for any item or service provided by an Indian health provider.<sup>13</sup>

Because this special rule has the potential to disadvantage a health plan operating in an Exchange or a health care provider that serves AI/AN, and could create disincentives for Exchange plans to enrollee AI/AN persons and for providers to serve AI/AN patients, the ACA drafters added section 1402(d)(3). That section states that “[t]he Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection” [*i.e.*, provisions (d)(1) and (d)(2) of § 1402]. As such, HHS is directed to make a payment to health plans that enrollee AI/AN in the individual market in an Exchange in an amount that offsets the additional costs associated with implementation of the waiver of cost-sharing requirements completely for AI/AN enrollees with family income at or below 300 percent of the poverty level (under section 1402(d)(1)) or waive cost-sharing for AI/AN enrollees with family income over 300% of the poverty level when they are served by I/T/U providers (under section 1402 (d)(2)).

NIHB offers that this payment by the Secretary to health plans serving AI/AN enrollees may be referred to as the “HHS Indian Offset.”

Taken together, the cost-sharing waiver (1402(d)(1) &(2)) and offset payment authorization (1402(d)(3)), are expected to greatly improve access to health care services for AI/AN. However, this favorable outcome depends on the strict enforcement of the cost-sharing protections and the timely payment of the “HHS Indian Offset” to health plans enrolling AI/AN.

As is the case for risk management mechanisms in general, timely payment is key to maximizing the benefit of the HHS Indian Offset mechanism. For health plans serving a significant percentage of AI/AN, and particularly for smaller plans (some of which may be operated by Tribes), timely payment of the HHS Indian Offset will be critical not only to ensure that resources for health care services are available when they are needed but also to ensure that such plans will be able to sustain themselves and survive over time.

Alternatively, if payments are not made or not made in a timely fashion, the health plans may view AI/AN enrollees as posing an excessive risk, and the health plans may avoid enrolling AI/AN. For health plans that do serve a significant number of AI/AN, the carrying costs of waiting for the HHS Indian Offset may be substantial. For smaller plans, the carrying costs may be prohibitive. For these reasons, we recommend that HHS pay the HHS Indian Offset on a monthly basis along with the base premium payments.

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<sup>13</sup> For purposes here, the cost-sharing protections apply to any item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

NIHB recommends placing the discussion and rulemaking for Section 1402(d) in this Proposed Rule because the HHS Indian Offset payment mechanism is similar in design and function to the risk adjustment, risk corridors and reinsurance mechanisms.

### **ACA Section 1001 / Section 2718 of the Public Health Service Act**

As modified by ACA section 1001, under section 2718(b)(1)(B) of the Public Health Service Act titled “Ensuring That Consumers Receive Value for Their Premium Payments,” insurers must rebate payments to plan enrollees, if plan revenues exceed plan medical expenditures by more than an allowable amount. Referred to as the medical loss ratio, plans are required to expend at least 85 percent of plan revenues (for large plans) or 80 percent of revenues (for insurers offering coverage in the small group market). Health plan revenues include “payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the [ACA] for such year”.<sup>14</sup> This provision is codified at 45 CFR Part 158, § 158.130.

The interim final rule (issued by HHS on December 1, 2010 titled “Health Insurance Issuers Implementing Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act”) briefly discusses including “the collections or receipts for risk adjustment and risk corridors and payments of reinsurance”<sup>15</sup> in the calculation of health plan premium revenue. The interim final rule indicates that “HHS anticipates providing guidance on these provisions at a later time.”<sup>16</sup>

The medical loss provision is designed to create incentives for plans to provide needed services to plan enrollees or to reduce plan premiums, either upfront when setting plan premium rates or through a subsequent rebate.

- NIHB recommends including the HHS Indian Offset payment provided for under ACA section 1402(d)(3) in the PHSA section 2718(b)(1)(B)(i) calculation for the total amount of plan premium revenue, along with the payments provided pursuant to the general risk adjustment mechanisms established under ACA section 1343.

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<sup>14</sup> ACA section 1001 modifying section 2718(b)(1)(B) of the Public Health Service Act titled “Ensuring That Consumers Receive Value for Their Premium Payments.”

<sup>15</sup> Federal Register, Vol. 75, No. 230, Wednesday, December 1, 2010, Interim Final Rule, Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act, page 74873.

<sup>16</sup> Federal Register, Vol. 75, No. 230, Wednesday, December 1, 2010, Interim Final Rule, Health Insurance Issuers Implementing Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act, page 74873.

# National Indian Health Board



## Establishment of Exchanges and Qualified Health Plans Implemented Consistent with Title I of the Patient Protection and Affordable Care Act<sup>1</sup> (CMS-9989-P; Proposed Rule)

### Analysis of Proposed Rule by the National Indian Health Board<sup>2</sup>

September 28, 2011

The National Indian Health Board (NIHB) appreciates the opportunity to provide comments on the Department of Health and Human Services' Proposed Rule, "Establishment of Exchanges and Qualified Health Plans," released July 15, 2011.

NIHB's comments follow the order of sections as presented in the Proposed Rule and reference the issue identifier, as per agency request.

#### PREAMBLE TO PROPOSED RULE

##### SUMMARY

The Proposed Rule Summary explains that the Center for Medicare and Medicaid Services (CMS) intends to afford States substantial flexibility in the design and operation of Affordable Insurance Exchanges (Exchanges), but proposes "greater standardization... where required by the statute or where there are compelling practical, efficacy, or consumer protection reasons."<sup>3</sup> Where American Indian issues are considered, NIHB urges CMS to use the approach of greater standardization. NIHB notes that American Indian law

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<sup>1</sup> Refers collectively to the Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and referred to herein as the Affordable Care Act or ACA.

<sup>2</sup> Established nearly 40 years ago, NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives. NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, NIHB is their advocate.

<sup>3</sup> Proposed Rule, page 41867.



and programs are almost exclusively Federal; the pertinent Federal laws apply to all Federally-recognized Tribes<sup>4</sup> in all States; and these Federal laws and the associated implementing regulations have supremacy over State laws and regulations. Furthermore, a host of Federal laws and regulations govern Tribes and Indian Health Care Providers<sup>5</sup> and impact the structure and policies of such providers. These Federal laws and regulations (including, but not limited to, the Indian Health Care Improvement Act, the Federal Tort Claims Act and the Anti-Deficiency Act<sup>6</sup>) will impact State-operated and Federally-operated Exchanges alike.

American Indians and Alaska Natives (AI/AN) are not the only ones that would benefit from standardization related to Indian health provisions. At an event sponsored by the Bipartisan Policy Center and the Kaiser Family Foundation on July 27, 2011, representatives of large insurance companies stated that it would be more difficult for them to work with 50 Exchanges with different rules and that they would prefer a more standardized approach. They also said that their biggest fear was adverse selection. Because of health disparities among the AI/AN population, there are incentives for issuers to avoid adverse selection by structuring plans to exclude American Indians and Alaska Natives (AI/AN). Requiring all plans to offer to include Indian health providers and to utilize the suggested addendum for Indian health system contracts – two recommendations presented later in these comments – would level the playing field for issuers as well as assure network adequacy for AI/AN consumers.

To have all 34 States with Federally-recognized Tribes negotiating the same points of Federal Indian law to reach the same conclusions already mandated by Federal law is inefficient and costly, particularly for those States that have few Tribes and where a very small portion of the population is AI/AN. In many States, it is the office of the State Insurance Commissioner that is responsible for planning Exchanges. While Tribes have established relationships with Medicaid Directors and directors of public health in their States, most Tribes have not developed relationships with insurance commissioners.

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<sup>4</sup> Do we want to qualify the term “Federally-recognized Tribe”? It seems contrary to our argument against CCHIO using “Federally-recognized Tribe” as the short-hand for definition of “Indian”.

<sup>5</sup> The term "Indian Health Care Provider" means the Indian Health Service (IHS), an Indian tribe, tribal organization or urban Indian organization, and is sometimes referred to collectively as "I/T/U". The term "Indian Health Service" means the agency of that name within the U.S. Department of Health and Human Services established by Sec. 601 of the Indian Health Care Improvement Act (IHCA), 25 USC §1661. The term "Indian tribe" has the meaning given that term in Sec. 4 of the IHCA, 25 USC §1603. The term "tribal organization" has the meaning given that term in Sec. 4 of the IHCA, 25 USC §1603. The term "urban Indian organization" has the meaning given that term in Sec. 4 of the "IHCA", 25 USC §1603.

<sup>6</sup> A more complete listing of the Federal laws and regulations affecting Indian Health Care Providers can be found in the Indian Addendum proposed by NIHB, the Tribal Technical Advisory Group to CMS (TTAG), and others to be used by Exchange plans when contracting with Indian Health Care Providers. (Refer to the letter and the attached draft Indian Addendum from TTAG to Dr. Donald Berwick dated April 13, 2011 titled “Indian Health Addendum for ACA Exchange Plan Provider Network Contracts”.) Also, see the discussion on the value of an Indian Health Addendum on page 41900 of the Federal Register contained in the Proposed Rule on Establishment of Exchanges and Qualified Health Plans (CMS-9989-P), published July 15, 2011.

Furthermore, most Insurance Commissioners do not have knowledge about Federal Indian law and the structure of Indian health services.

### Standards & Compliance with Existing Law

With regard to Indian health services, the exchanges need to be compliant not only with the ACA and the SSA, but also with the federal law that governs Indian health care: federal laws and regulations affecting an Indian health care provider include, but are not limited to, the following:

(a) The IHS as an Indian health care provider:

- (1) The Anti-Deficiency Act 31 U.S.C. § 1341;
- (2) The Indian Self Determination and Education Assistance Act ("ISDEAA") ; 25 USC §450 et seq.;
- (3) The Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
- (4) The Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
- (5) The Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 CFR Part 5b;
- (6) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2;
- (7) The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45C.F.R. Parts 160 and 164; and
- (8) The IHCA, 25 U.S.C. § 1601 et seq.

(b) An Indian Tribe or a Tribal organization that is an Indian health care provider:

- (1) The ISDEAA, 25 USC § 450 et seq.;
- (2) The IHCA, 25 USC § 1601, et seq.;
- (3) The FTCA, 28 USC §§ 2671-2680;
- (4) The Privacy Act, 5 USC §552a and regulations at 45 CFR Part 5b;
- (5) The HIPAA, and regulations at 45 CFR parts 160 and 164; and
- (6) Sec. 206(e)(3) of the IHCA, 25 USC §1621e(e)(3), regarding recovery from tortfeasors.
- [(7) Possibly include citation of law(s) pertaining preference in hiring for AI/AN.]**

(c) An urban Indian organization that is an Indian health care provider:

- (1) The IHCA, 25 USC § 1601, et seq.;
- (2) The Privacy Act, 5 USC § 552a and regulations at 45 CFR Part 5b;
- (3) The HIPAA, and regulations at 45 CFR parts 160 and 164; and
- (4) Sec. 206(e)(3) of the IHCA, 25 USC §1621e(e)(3), regarding recovery

from tortfeasors, as made applicable to urban Indian organizations by Sec. 206(j) of the IHCA.

To assure compliance with this body of federal Indian law, the most efficient approach is to require that all QHPs offer contracts to all I/T/Us in the state with the suggested Indian health addendum that sets out these requirements.

In addition to the above, section 206 of the IHCA established a “right of recovery” for I/T/U for services rendered to AI/AN who are covered by insurers and other third party entities. Under this provision of federal law, if an I/T/U decides to exercise this right, a health plan or other liable third party entity, including Exchange plans, is required to compensate the I/T/U for services rendered to AI/AN who is covered by their plans at a rate that is the higher of 1) the reasonable charges billed by the I/T/U or 2) the highest amount the third party would pay to other providers.

### Areas for Innovation

While NIHB believes that exchanges would benefit from having clear rules about AI/AN benefits and I/T/U providers, we also appreciate the idea that exchanges create the opportunity for innovation. In certain areas, we believe that states should have the flexibility to work with Tribes in ways that best respond to the local situation. For example, outreach, education and enrollment assistance are activities where culturally-appropriate approaches and innovation may be encouraged. NIHB urges the drafters to carefully consider Tribal input to discover additional areas where it may be beneficial to be flexible and open to innovation,

In addition to our overview recommendations involving standardization, NIHB offers comment on the executive summary’s declaration that “[e]xchanges will offer Americans competition, choice and clout[,] [i]nsurance companies will compete for business on a level playing field,” and these factors will “driv[e] down costs.”

While NIHB supports the goal of creating a platform for price competition, we must point out the fact that in remote places where many Tribes reside, the population density is too low for market forces to create competition. In remote, low-density areas, it is unlikely that exchanges will lower the cost of delivering services to AI/AN. In fact, the Indian health system has long been underfunded. In these areas, more resources, not less, are required. NIHB urges the drafters to take these realities into consideration as they create and revise rules that will govern the exchanges.

## I. BACKGROUND

### A. LEGISLATIVE OVERVIEW

## 1. Legislative Requirements for Establishing Exchanges

As explained in this section of the preamble to the Proposed Rule, section 1321(c)(1) of the ACA requires the Secretary to establish and operate an Exchange in States that forgo establishing an Exchange, or, as determined by the Secretary on or before January 1, 2013, cannot establish an operable Exchange by January 1, 2014. This directive creates the imperative for the Secretary to establish the blueprint for federal Exchanges, while subsection (a) of the same section provides the authority for the Secretary to establish standards and regulations applying to both Federal as well as State Exchanges. Section 1321(a)(2) also requires the Secretary to engage in consultation to ensure balanced representation among interested parties.

Because of the potential impact of Section 1321, in the context of operating a Federal Exchange and in the creation of a template and standard, NIHB urges CMS to consult with Tribes about the development of a federal Exchange(s). Some States with substantial AI/AN populations, such as Alaska, have already indicated that they are not planning to operate a state Exchange. Other States are also likely to not take on the responsibility of establishing and operating an Exchange. As such, NIHB believes that the Federal Exchange holds the potential to greatly impact health care options for AI/AN. NIHB stresses that comments on this Proposed Rule should not serve as a substitute for CMS consultations with Tribes on the design and operation of a Federal Exchange.

## 2. Legislative Requirements for Related Provisions

The discussion offered in the Proposed Rule states that some of the special benefits and protections to American Indian/ Alaska Natives are included in this Proposed Rule in Section 156, Subpart C, while other benefits and protections will be addressed in future rulemaking.

The addressing of AI/AN-specific benefits and protections in a series of proposed rules, without knowing the content of future proposed rules, makes it difficult to offer comments on potential omissions. NIHB recommends that CCIIO provide a table with the special AI/AN and I/T/U provisions in the ACA and indicate where these provisions will be addressed in the proposed rules.

### **B. STAKEHOLDER CONSULTATION AND INPUT**

According to the Proposed Rule, HHS has been holding weekly meetings with the National Association of Insurance Commissioners (NAIC). In many States, Insurance Commissioners are the entities charged with planning for State health insurance Exchanges.

NIHB strongly urges CMS to work with Tribes to undertake a thorough education of State health insurance commissioners on issues related to Indian law, the structure of the Indian health care delivery system, and protocols for consulting with Tribes.

These efforts are necessary and prudent. Tribes have fairly well- developed relationships with State Medicaid Directors and State Public Health Directors, but most Tribes have no relationship or experience working with State insurance commissioners. Some Tribal representatives who have tried to contact their State’s health insurance commissioner have reported that their phone calls are not returned, or that the health insurance commissioner knows nothing about Tribes or Tribal consultation.

In addition to supporting a push to educate Insurance Commissioners, NIHB suggests that this evidence provides yet another reason to standardize requirements for AI/AN in Federal regulations. Standardization would assure that the intent of the law is – efficiently and effectively – carried out with respect to participation by Indian consumers and Indian health providers.

## **SUBCHAPTER B – REQUIREMENTS RELATING TO HEALTH CARE ACCESS**

### **A. PART 155 – EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE ACA**

#### **SUBPART A –GENERAL PROVISIONS**

##### **155.10 BASIS AND SCOPE.**

##### **155.20 DEFINITIONS.**

#### **SUBPART B –GENERAL STANDARDS RELATED TO THE ESTABLISHMENT OF AN EXCHANGE BY A STATE**

##### **155.100 ESTABLISHMENT OF A STATE EXCHANGE.**

Section 1311(d)(6) of the Affordable Care Act requires Exchanges to consult with certain groups of stakeholders as they establish their programs and throughout ongoing operations. The Proposed Rule directs that each Exchange that has one or more Federally-recognized Tribes located within its geographic region must engage in regular and meaningful consultation with such Tribes and their officials. The Proposed Rule further clarifies that consultation is a government-to-government process with a key role being filled by the State. The Proposed Rule encourages States to develop a Tribal consultation policy that is to be approved by the State, the Exchange, and Tribes.

The Proposed Rule at paragraph (b) of §155.100, will codify section 1311(d)(1) of the Affordable Care Act so that an Exchange must be a governmental agency or non-profit entity established by the State. Some States have passed legislation establishing Exchange

governing bodies as independent public entities with minimal oversight by the State. These entities may report directly to consumer advisory councils or directly to State legislatures. In these circumstances, it may be difficult to require and monitor “regular and meaningful” consultation.

NIHB recommends revising the Proposed Rule to prohibit States from delegating their Tribal consultation duty to governing bodies established to operate Exchanges. NIHB also suggests that the Proposed Rule require HHS approval of a State’s Tribal consultation policy before a State Exchange Plan can receive approval. This measure would ensure that requirements set out in §155.130 are met. Under our proposal, a Tribal consultation policy would be developed and approved by the State, the Exchange and by Tribal governments prior to the submission of a State Exchange Plan for approval by HHS.

If consultation requirements are not enforced, it is highly likely that governing bodies established to operate Exchanges will not fulfill requirements for Tribal consultation in a meaningful way. This has been the experience of Tribes nationally in the Medicaid program. Experience has demonstrated that States have often failed to establish viable mechanisms to ensure meaningful Tribal input into matters that affect them. To correct this situation, § 5006(e) of the American Recovery and Reinvestment Act (ARRA) amended the Social Security Act at § 1902(a)(73), to require that States utilize a process to seek advice on a regular, ongoing basis from designees of the Indian Health Programs and Urban Indian Organizations concerning Medicaid and CHIP matters that have a direct effect on Indians, Indian Health Programs or Urban Indian Organizations. A similar requirement must be established in the final rules for Exchanges.

NIHB also recommends that CMS extend the authority and responsibility of the CMS Native American Contacts to include facilitating and interacting with the State Exchange governing and administrative bodies, as well as with Tribes on Exchange-related issues. In addition, we recommend that, as a component of the ongoing requirement for tribal consultation, Exchanges be required to establish an “Indian desk” with the lead person(s) identified and contact information made readily available.

#### **155.105 APPROVAL OF A STATE EXCHANGE.**

This portion of the Proposed Rule sets out the State Exchange approval standards and the approval process. Noticeably absent is the requirement that States show they have complied with Tribal consultation mandates. Also absent is the requirement that States agree to comply with AI/AN specific provisions under the rules and law. Although the Proposed Rule requires a State to show that its Exchange “is able to carry out the required functions of an Exchange” and that the exchange demonstrate “operational readiness,” neither of these measures provide an assurance that the State will perform its responsibilities under AI/AN and Tribal provisions.

The HHS approval process for State health insurance Exchanges should include standards related to the Exchange's ability to identify AI/AN and ensure that the benefits and protections in the law are carried out through the Exchange, including waiving cost sharing. Furthermore, as required under section 408 of the IHCA and discussed later in these comments, the approval process should ensure that States with I/T/U providers require health plans offered in an Exchange to offer to contract with all I/T/U providers in that State. Also, HHS approval should require States to demonstrate that they have carried out meaningful consultation with Tribes in the design of the Exchanges.

To ensure these requirements are met, NIHB recommends that HHS conduct an assessment of implementation of AI/AN provisions and tribal consultation as part of the 'readiness assessment' process and the grants monitoring process (for State planning and establishment grants). That assessment should include reporting on specific matters by the State officials responsible for designing health insurance Exchanges, and should also include a mechanism for the I/T/U to comment directly to HHS.

The Proposed Rule requests input and comments about the utilization of the State plan amendment process similar to the process for Medicaid and CHIP for significant changes to the Exchange Plan. It is imperative that a formal process be established for Exchanges to make such changes. We believe that the State plan amendment process can serve as an effective mechanism for obtaining written approval. In instances when approval is not granted it can serve as a process for providing the Exchanges technical assistance in order to achieve approval and compliance. The process is well understood by State Medicaid programs and can serve as a model for the Exchange.

The Proposed Rule proposes that a State must notify HHS before significant changes are made to the Exchange Plan and receive written approval from HHS. The Medicaid and CHIP State Plan Amendment process is considered the model.

NIHB believes that the tribal consultation requirements for State Plan Amendments should also be applied to Exchange Plan amendments. In particular, the Recovery Act added a provision to the Social Security Act requiring States to solicit advice from I/T/U providers prior to submission of a Medicaid State plan amendment. The section reads as follows:

[I]n the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that— **“(A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations.”**<sup>7</sup> (emphasis added)

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<sup>7</sup> American Recovery and Reinvestment Act, section 5006(e).

NIHB recommends that such a requirement be included with the general requirement for Exchanges to use a State Plan Amendment-like process. NIHB also recommends that HHS require Exchanges to complete a preprint form documenting Tribal consultation procedures similar the preprint required for State plan amendments, which was distributed in CMS-SMDL#: 10-001. Among the significant changes that should trigger an HHS review are any changes that would affect the ability of AI/AN to access Exchanges and to receive the full benefits and protections under the law.

If HHS does not approve an Exchange in a State and elects instead to establish a Federally-facilitated Exchange, then HHS should consult with Tribes about the design of the Exchange to ensure that the benefits and protections for AI/AN are included in the Exchange design, and that it is workable for the I/T/U.

Finally, we suggest that HHS include an additional standard for approval of a State Exchange. This standard should assess the economic viability of the Exchange and ensure that fees charged to issuers are not passed along to providers and consumers. [In the MLR rules, is fee that is assessed to plans to cover Exchange administrative costs included in admin or claims?] In States with small populations, the diseconomies of scale combined with the Exchange requirements may create high administrative costs that could be passed along to the providers and consumers. The budget and financing structure for the Exchange after January 1, 2015, should be part of the Exchange plan approval process and ensure that fees charged to issuers are not passed along to providers and consumers.

#### **155.106 ELECTION TO OPERATE AN EXCHANGE AFTER 2014.**

As Exchange responsibilities are moved from Federal to State, or State to Federal, there should be Tribal consultation to ensure that AI/AN receive the benefits and protections prescribed by law, that there is appropriate communication with Indian consumers, and that the resulting changes do not disrupt services and payments to the I/T/U.

#### **155.110 ENTITIES ELIGIBLE TO CARRY OUT EXCHANGE FUNCTIONS.**

The Proposed Rule describes a partnership model between State and Federal governments with the sharing of information and ideas. NIHB believes that Tribal Governments should be included in the partnership model.

This portion of the Proposed Rule also sets out the requirements regarding conflict of interest. In response to the request for comments on conflict of interest requirements on contracting entities, NIHB offers several comments and suggestions.

NIHB supports transparency and clear rules about conflict of interest. With regard to Tribes specifically, NIHB urges that the rules acknowledge the multifaceted role that Tribal governments play. Tribes should be treated as governments that both provide services and advocate on behalf of their citizens. The rules should explicitly include Tribes

as eligible for contracting portions of the Exchange operations that are contracted to non-profit organizations.

The proposed standards for membership on the governing board of an Exchange seem reasonable. However, NIHB recommends including designated seats for underrepresented populations, including AI/AN. NIHB also recommends including AI/AN health care experts in section (c)(4) of the rule, to encourage boards to seek candidates with relevant experience in the Indian health care delivery system.

The Proposed Rule explains that Exchanges may establish contracting arrangements with outside entities. These arrangements could include outsourcing such activities as subsidy determinations or payer arrangements to issuers.

NIHB emphasizes that subcontracting does not relieve States from their obligation to conduct Tribal consultations for the operations subject to subcontracting. As part of the periodic review, NIHB recommends that HHS assess whether or not ongoing Tribal consultation requirements are being met. Similarly, NIHB suggests that HHS use periodic reviews to ensure that the contracting entities meet all Federal requirements related to providing services to AI/AN people and coordinating arrangements with IHS and Tribally-operated health programs.

#### **155.120 NON-INTERFERENCE WITH FEDERAL LAW AND NON-DISCRIMINATION STANDARDS.**

The Proposed Rule indicates that States must comply with non-discrimination statutes and not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. The regulations should explicitly acknowledge the unique category of “Indian”<sup>8</sup> and refer to Federal Indian law that allow limiting Indian Health Services to Indians (as defined by IHS) and using Indian preference in hiring, including:

(a) The IHS is limited to serving eligible IHS beneficiaries pursuant to 42 CFR Part 136 and Sec. 813 of the IHCA, 25 USC § 1680c.

(b) Persons eligible for services of an Indian Health Care Provider that is an Indian Tribe or a tribal organization or a Provider who is an urban Indian organization are governed by the following authorities:

(1) Sec. 813 of the IHCA, 25 USC §1680c;

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<sup>8</sup> As U.S. and state citizens, individual AI/AN possess the same constitutional rights as every other citizen, including the rights of equal protection. However, the term “Indian” does not always designate a racial category. In some situations, “Indian” designates a political category, and does not trigger the heightened scrutiny that unequal treatment of racial categories would. Even when “Indian” does designate a racial category, compelling government interests (i.e. - upholding treaty promises, correcting historical discrimination) and narrowly tailored measures will defeat equal protection challenges. *See* Morton v. Mancari, 417 U.S. 535 (1974); *United States v. Antelope*, 430 U.S. 641 (1977); *Means v. Navajo Nation*, 432 F.3d 924 (9<sup>th</sup> Cir. 2005).

(2) 42 CFR Part 136; and

(3) The terms of the contract, compact or grant issued to such Indian Health Care Provider by the IHS.

(c) The IHS and Tribes may exercise Indian Preference in employment decisions per the following authority:

(1) 25 U.S.C. § 450e(b);<sup>9</sup> and

(2) *Morton v. Mancari*.<sup>10</sup>

This will be confusing to many issuers, and as such, NIHB believes that everyone would be best served by requiring Exchanges to use a standard “Indian addendum” for contracts with issuers that has been developed by the Tribal Technical Advisory Group to CMS (TTAG), which is similar to the addendum used for Indian health pharmacy participation in the Medicare Part D program.

The Proposed Rule specifically cites intent to prohibit discrimination in areas such as marketing, outreach and enrollment. Again, NIHB believes it is essential, as well as lawful, to conduct specific marketing, outreach and enrollment programs for AI/AN. Considering the historic under-enrollment in programs such as Medicaid, special approaches are needed to assure full participation of AI/AN in Exchanges. To clarify that these activities are not discriminatory, the rules should explicitly authorize these actions.

### **155.130 STAKEHOLDER CONSULTATION**

NIHB commends HHS for including Tribes as stakeholders in the Proposed Rule. This requirement runs parallel to requirements under the [insert statutory requirement for consultation with Tribes. Sec. 5006(e) is a statutory requirement for seeking advice from I/T/U.] Tribal consultation is paramount to ensure AI/AN benefit from Exchange programs

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<sup>9</sup> Holding that “Any contract, subcontract, grant, or subgrant pursuant to [the ISDEAA]. . . or any other Act authorizing Federal contracts with or grants to Indian organizations or for the benefit of Indians, shall require that to the greatest extent feasible (1) preferences and opportunities for training and employment in connection with the administration of such contracts or grants shall be given to Indians; and (2) preference in the award of subcontracts and subgrants in connection with the administration of such contracts or grants shall be given to Indian organizations and to Indian-owned economic enterprises as defined in section 1452 of this title.”

<sup>10</sup> 417 U.S. 535 (1974). See also *id.* at 554 (holding that an Indian employment preference “is an employment criterion reasonably designed to further the cause of Indian self-government and to make the [employer] more responsive to the needs of its constituent groups.”). *Accord Solomon v. Interior Reg’l Hous. Auth.*, 313 F. 3d 1194, 1199 (9th Cir. 2002) (“Congress’ stated purpose in enacting the ISDEAA was to increase Indian tribal autonomy in running federally administered programs.”); *Alaska Chapter, Associated Gen. Contr. v. Pierce*, 694 F. 2d 1162, 1168 (9th Cir. 1982) (“*Mancari* simply held that, as long as the special treatment is rationally related to Congress’ unique obligation towards the Indians, the preference would not violate equal protection. If the preference in fact furthers Congress’ special obligation, then *a fortiori* it is a political rather than racial classification, even though racial criteria might be used in defining who is an eligible Indian.”).

and other aspects of the Affordable Care Act. Indian Tribes play multiple roles in the health care system as governmental entities, direct care providers, employers, purchasers of health care, and beneficiary advocates. This makes Tribes stakeholders in the health care system on multiple levels.

NIHB recommends retention of the requirement for Exchanges to consult with Tribes at §155.130. We also advise that HHS require States to submit a Tribal consultation policy approved by the State, the Exchange, and Tribes as a condition to approve a State's Exchange Plan. This requirement will create the incentive to collaborate and build strong working relationships between Tribes and States in developing the Exchanges.

#### **155.140 ESTABLISHMENT OF A REGIONAL EXCHANGE OR SUBSIDIARY EXCHANGE.**

This portion of the Proposed Rule sets out the requirements to establish and/ or participate in a regional Exchange. A regional Exchange may be an attractive option for States with relatively small populations and may be particularly welcome by both Tribes and States where a Tribe spans the borders of two or more States. The Navajo Nation provides a good example of this situation as the Nation's land lies in Arizona, New Mexico, and Utah. Although we believe regional Exchanges offer promising potential, NIHB is concerned about the way regional Exchanges would address tribal consultation, AI/AN protections and benefits, and relationships with the I/T/U.

We note the finding that tribal governments would not be able to operate a regional or subsidiary Exchange. However, the language of the Proposed Rule seems to leave open the option of tribal governments carrying out some of the functions of an Exchange. The language states "the tribal government could work with the State as the State establishes an Exchange." NIHB believes that Tribes and tribal organizations could have a larger and more continuous role as contractors with the Exchange for such things as marketing, outreach, enrollment and other business functions. Some Tribes and tribal organizations are also incorporated as non-profit organizations. NIHB recommends revising the text to clarify that the rules permit Tribal governments to carry out components of the Exchange.

#### **155.150 TRANSITION PROCESS FOR EXISTING STATE HEALTH INSURANCE EXCHANGES.**

#### **155.160 FINANCIAL SUPPORT FOR CONTINUED OPERATIONS.**

To ensure that their Exchange has the necessary funding to be self-sufficient by January 1, 2015, the Proposed Rule allows a State to charge assessments or user fees on participating issuers. NIHB is concerned that these fees may be passed along to I/T/U providers or AI/AN consumers.

It is reasonable to assume that most issuers are for-profit insurance companies who will have business incentives to share or pass their costs onto providers. Not-for-profit I/T/U providers simply cannot absorb the cost of the fees to operate the Exchange. Furthermore, IHS funding should not be used to pay fees to support Exchanges. NIHB suggests adding

language that states that the cost of fees for the Exchange will count toward the 15 percent that QHPs may retain for administrative functions.

Section 155.160 paragraph (3) states that no Federal funds “will be provided” after January 1, 2015, to support continued operation of Exchanges. It is not clear whether the rule prohibits the use of Federal funds to support Exchange operations, or merely states the government’s intention with regard to further funding. Since Exchanges will also be performing eligibility and enrollment functions for Medicaid and SCHIP, a portion of Federal Medicaid and SCHIP administrative funding should be allowed to pay for Exchanges. Furthermore, IHS funding could be used to support AI/AN enrollment assistance activities.

NIHB advocates for an HHS role in reviewing the rates and structure of fees for Exchanges operated by States. Similarly, an independent agency should review fees and fee structures for a Federal Exchange.. We have recently seen new Medicare regulations that assess fees to providers and these fees have been passed along to the Indian health system, thereby reducing the amount of funding available to serve AI/AN.

The budget and financing structure for the Exchange should be part of the Exchange plan approval process to assure that fees are not excessive and that they are not passed along to providers and consumers.

#### SUBPART C – GENERAL FUNCTIONS OF AN EXCHANGE

##### **155.200 FUNCTIONS OF AN EXCHANGE.**

##### **155.205 REQUIRED CONSUMER ASSISTANCE TOOLS AND PROGRAMS OF AN EXCHANGE.**

Section 155.205 (a) Call center. For call centers to be helpful for AI/AN, the call center employees must be trained to understand the Indian health system and offer options that includes their I/T/U providers. Call center representatives must also have extensive training on benefits and protections for AI/AN in ACA, ARRA, CHIPRA, and IHS. One option is to have a special “Indian desk” to assist AI/AN consumers and I/T/U providers. Staffing for the Indian desk should include people who are not only knowledgeable about these issues, but also are empowered to fix problems. Call centers should establish relationships with I/T/U so they can refer people to I/T/U clinics for enrollment assistance and can support those I/T/U clinics in solving problems as they arise.

Section 155.205 (b)Internet Website. The website should make it easy for AI/AN to find out whether I/T/U providers are included in QHPs. Furthermore, all providers – medical and pharmaceutical -- must be able to identify a patient as an AI/AN who is eligible for the waiver of cost-sharing by ACA Sec. 1402(d).

Section 155.205 ( c) Exchange calculator. Rules governing AI/AN cost sharing are different from other populations. The website should identify AI/AN who qualify for waiver of cost sharing and the calculations should reflect this protection.

Section 155.205 (c)(4) Contact information. Contact information on the website should include consumer assistance service offered by the I/T/U. We support the idea that information can be saved by people who are assisting in the enrollment process. However, we are concerned that this could lead to duplication of efforts and unscrupulous practices by those who profit from their role as Navigators.

Section 155.205 (d) Consumer assistance. We strongly support a consumer assistance function that assists with enrollment, and resolves issues and complaints. For this to be effective, the Exchange must have trained employees who understand the Indian health system and have the power to make decisions. For Medicare Part D, it was essential to have people empowered to correct mistakes and fix system problems specific to AI/AN consumers and Indian Health Providers.

Section 155.205 (e) Outreach and education. Exchanges should work closely with Tribes and the I/T/U to develop outreach and education efforts. Health insurance literacy is low among the general population in the United States, and it is less understood by AI/AN who primarily have relied upon the Federal Indian health system over the years. Explaining how health insurance works should be done within a cultural and historic context, and should acknowledge and explain how the federal trust responsibility and the requirements of Federal Indian laws affect and interact with new laws, rules and policy. The most trusted people to assume this task are people working for Tribes and the I/T/U. An effort conceived and directed from outside the AI/AN community is unlikely to succeed.

#### **155.210 NAVIGATOR PROGRAM STANDARDS.**

Paragraph (b)(1)(iii) proposes that Navigators must meet licensing, certification or other standards prescribed by the State or Exchange. NIHB recommends revising this requirement and examining alternative approaches to licensing and certification.

There is a long history of jurisdictional problems associated with State licensing and certification of tribal employees. State control over this aspect of an Exchange is especially inappropriate when the Federal government is operating the Exchange. This requirement raises several concerns. First, a State or Exchange could see fit to impose licensing fees on Navigators serving only AI/AN populations. A State could require Navigators to serve everyone, which would take resources away from the already stressed Indian health system. Or, people working as alternate resource specialists in the I/T/U clinics and hospitals could be prohibited from assisting people in the enrollment process (even if they were not paid by the Exchange) if they were not licensed to be Navigators.

An alternative way to assure the safety and quality of Navigators is to offer a training program; the training program, in turn, could award credentials to identify individuals qualified to work as Navigators.

Conflict of interest, mentioned in paragraph (b)(1)(iv), can be problematic for Tribes. Tribal governments both provide services and advocate for tribal members. In many tribal

communities there is a different perception of conflict of interest than in other places, in part because there are so few people and leaders must wear many hats. The rules should explicitly exempt I/T/U employees who serve as Navigators from conflict of interest requirements. Of course, if the regulations require all QHPs to offer contracts with the Indian Addendum to all I/T/U providers in the State, then there would be no need to direct AI/AN to plans with I/T/U providers, and this would generally eliminate the conflict of interest issues.

NIHB notes that the rules require the Navigator to provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. NIHB fully endorses this requirement and urges its retention in the final rule.

Because one function of a Navigator is to “conduct public education activities,” NIHB recommends that training and funding for this program begin 6 months or more in advance of the initial open enrollment period. We acknowledge the financial difficulty inherent in this recommendation since Establishment Grants cannot be used for this purpose and Exchanges would not yet be able to charge fees to issuers. This would shift the burden of funding to States. It is not clear how HHS would fund Navigator grants for Federally-operated Exchanges. NIHB recommends the drafters address this start-up funding issue in the final rule.

#### **155.220 ABILITY OF STATES TO PERMIT AGENTS AND BROKERS TO ASSIST QUALIFIED INDIVIDUALS, QUALIFIED EMPLOYERS OR QUALIFIED EMPLOYEES ENROLLING IN QHPs.**

The language in Section 155.220 (b) implies that advertising for insurance agents and brokers could appear on Exchange websites. As States look for ways to defray the costs of the Exchange, and the costs of the Navigator grants in particular, the pressure to capitalize on advertising will intensify.

NIHB advises against permitting advertising. Allowing advertising creates the potential for a variety of abuses. Rather than using advertising to subsidize the costs of Exchanges, Exchanges could end up essentially subsidizing the advertising costs of a few vested interests. Advertising for brokers and insurance agents could create confusion for people already overwhelmed by the available information. Perhaps most importantly, it would add an element of commercialization to the Exchanges that would undermine the credibility of the institution. NIHB suggests that this provision be eliminated.

#### **155.230 GENERAL STANDARDS FOR EXCHANGE NOTICES.**

NIHB recommends including language to permit an individual enrollee to designate an I/T/U facility address as their mailing address for Exchange notices. [Do we want to include specific language?]

NIHB also recommends including language allowing AI/AN to designate a representative of the I/T/U facility to receive additional information over the telephone and to respond to notices.

#### **155.240 PAYMENT OF PREMIUMS.**

Paragraph (b) states that “Exchange[s] may permit Indian tribes, tribal organizations and urban Indian organizations to pay QHP premiums on behalf of qualified individuals, subject to terms and conditions determined by the Exchange.”<sup>11</sup>

[Under SHOP Exchange, ACA only requires Secretary to “to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State”, yet Exchanges are “required” to accept payment by employers on behalf of employees. Create a parallel requirement here, tied to the new authority under IHCIA sec 402 for T/TO/U to purchase health benefits coverage for IHS beneficiaries.]

NIHB urges eliminating the qualifier, “subject to the terms and conditions determined by the Exchange.” This condition does not apply to employers in paragraph (c). If the Exchange accepts aggregate payments from employers, it should also accept payment from Tribes for individuals they choose to sponsor. By giving State Exchanges the opportunity to impose terms and conditions, the intent is undermined. This is an area where Tribes and States should work together to develop processes that encourage the enrollment of eligible people into QHPs.

The definition of IHS beneficiaries who qualify for Federal funds to be used to purchase premiums is fairly straight forward. Under Section 402 of the IHCIA, "Indian Tribes, tribal organizations and urban Indian organizations" may use Federal funds to purchase health benefits coverage. These Federal funds may be used to purchase coverage for IHS beneficiaries in any manner, including (but not limited to) through a tribally owned or operated health care plan, a State or locally authorized or licensed health care plan, a health insurance provider or managed care organization, a self-insured plan, or a high deductible or health savings account. In addition, Tribes may have other resources that they may choose to use to purchase premiums without regard to those restrictions.

NIHB notes an error in the discussion for this section regarding Tribal participation in the Medicare Part D Prescription Drug Program. The narrative states that “Under that program, Tribes offer a selection of plans from which their members may choose, thus limiting the members’ options.” In fact, Tribal members can elect to enroll in any insurance at any time, as long as they are willing to pay any applicable premiums. In some cases, such as Medicare Advantage, there may be no additional premiums for individuals. The Tribes may decide if they are going to pay premiums for some or all of their members. This essentially *expands* the options of tribal members. If Tribes decide to pay premiums, they may reduce the administrative costs of enrollment management, coordination of care, and

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<sup>11</sup> Proposed Rule, p. 41916.

billing for services rendered by limiting the number of plans or insurance companies with whom they do business.

Request for Comment on Application of Definition of Indian (p.41879)

In a number of locations in the Proposed Rule, clarification of the definition if Indian is requested. These include § 155.240 on Payment of Premiums, § 155.350 on Cost Sharing, and § 155.420 on Special Enrollment Period. The discussion that follows is relevant to the Payment of Premiums section, as well as the cost sharing and special enrollment provisions.

The Proposed Rule incorrectly states:

For purposes of determining eligibility for cost-sharing provisions, we propose to codify the definition of “Indian” to mean any individual defined in section 4(d) of the Indian Self Determination and Education Assistance Act (ISDEAA) (P. L. 93-638, 88 Stat. 2203), in accordance with section 1402(d)(1) of the Affordable Care Act. This definition means an individual who is a member of a Federally-recognized tribe. Applicants meeting this definition are eligible for cost-sharing reductions or special cost-sharing rules on the basis of Indian status, which are described in §155.350 of this subpart. (Emphasis added.)

This an excessively narrow view of the law, a view that is not supported by a careful reading of the relevant legal provisions. A careful reading of the law shows that there is no appreciable distinction between the definition of “Indian” or “Indian tribe” in the Indian Health Care Improvement Act, P.L. 94-437, as amended, 25 U.S.C. §1601 et seq. (hereinafter “IHCA”) and the definition of “Indian” in the Indian Self-Determination and Education Assistance Act, P.L. 93-636 as amended, 25 U.S.C. §450 et seq. (hereinafter “ISDEAA”). Most important, neither act requires that an “Indian” must be a member of a federally-recognized tribe. California Indians, whose continuing eligibility for health care services was confirmed Congress more than three decades ago through the adoption of 25 U.S.C. Section 1679, qualify for health care under the definitions in both Acts as will be demonstrated below.

Similarly, at 76 Federal Register 41884, in the Proposed Rules that have been published regarding the Patient Protection and Affordable Care Act and Establishment of Exchanges and Qualified Health Plans, the following is found:

In paragraph (d)(8), we propose to codify the statutory special enrollment period that Indians receive a monthly special enrollment period as specified in section 1311(c)(6)(D) of the

Affordable Care Act. We interpret the monthly special enrollment period to allow for an Indian to join or change plans one time per month. For purposes of this special enrollment period, section 1311(c)(6)(D) defines an Indian as specified in section 4 of the Indian Health Care Improvement Act (IHCIA). Section 4 of the IHCIA defines “Indian” as a member of a Federally-recognized tribe. (Emphasis added,)

As is clearly demonstrated below, neither the ISDEAA or the IHCIA define an Indian only as a member of a “Federally-recognized tribe.” For the reasons set forth below, the language in these proposed regulations is legally incorrect and must be corrected.

The discussion that follows demonstrates that: (1) the definition of “Indian” is the same in the ISDEAA and the IHCIA; (2) that definition does not require an Indian to be a member of a federally-recognized tribe; (3) California Indians are clearly eligible as “Indians” under the definitions in both Acts; (4) California Indians are eligible to carry out ISDEAA contracts whether or not they are members of federally-recognized tribes by subcontracting with the California Rural Indian Health Board (CRIHB); and (5) the long-standing canons of statutory construction require that the ISDEAA and the IHCIA be employed to liberally construe these definitions for the benefit of the Indians.

1. Definition of “Indian” is the same in the ISDEAA and the IHCIA.

The definition of “Indian” in the Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended, 25 U.S.C. §450 et seq. (hereinafter referred to as the “ISDEAA”) is found at 25 U.S.C. §450 b(d) which defines an Indian as:

“a person who is a member of an Indian tribe”

Similarly, the definition of “Indian” in the Indian Health Care Improvement Act, P.L. 94-437, as amended, 25 U.S.C. §1601 et seq. (hereinafter referred to as “IHCIA”), is found at 25 U.S.C. §1603(c) which defines an Indian as:

“any person who is a member of an Indian tribe, as defined in subsection (d) of this section”<sup>12</sup>

Thus the basic definition of “Indian” in both Acts is identical. Both mean Indians are individuals who are “members of an Indian tribe.”

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<sup>12</sup> This provision in the Indian Health Care Improvement Act goes on to say that certain other Indians such as state recognized Indians and Alaska Natives are eligible for health professions scholarships and training activities, none of which are relevant to the discussion herein.

2. Definition of “Indian Tribe” is the same in the ISDEAA and the IHCIA.

Just as the definitions of “Indian” are indistinguishable between the ISDEAA and the IHCIA, the definitions of “Indian Tribe” in the two laws are nearly identical.

In the ISDEAA, the definition of “Indian Tribe” is found at 25 U.S.C. §450b(e) which says that “Indian tribe” means:

any Indian tribe, Band, nation or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act [cit. om.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians;

In the IHCIA, the definition of Indian Tribe is found at 25 U.S.C. §1603(d) which defines Indian tribe to mean:

any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act [cit.om.], which is recognized as eligible for special programs and services provided by the United States for Indians because of their status as Indians.

From reviewing these two definitions, one can see that they are virtually identical. The only variation from one to the other involves a slight difference in regard to the wording used in relation to Alaska Natives, with the IHCIA including any Alaska Native “village or group” in addition to regional or village corporations which are included in both definitions.

Most important is that neither definition refers to or requires that an Indian Tribe be a “federally-recognized” tribe or on the list of federally-recognized tribes. Instead, a “tribe” may be any tribe, band, nation, or other organized group or community which is “recognized as eligible for special programs and services provided by the United States for Indians because of their status as Indians.”

As will be demonstrated below, California Indians fall clearly within the definition of “Indian tribe” set forth in both the IHCIA and the ISDEAA. In fact, Congress insured that the California Indians who were not members of federally-recognized tribes would continue to be eligible for programs and services operated by the Indian Health Service (hereinafter IHS) in the face of threats by the IHS to discontinue those programs and services in the late 1970’s and early 1980’s. These same California Indians are and have always been eligible for various BIA programs as well. Going back to at least 1921 when the Snyder Act, 25

U.S.C. Section 13, was enacted, Congress has provided specific funding to serve “Indians throughout the United States,” including those in California, for “relief of distress and conservation of health,” irrespective of whether they were members of federally-recognized tribes.<sup>13</sup> Congress also insured that California Indians would continue to be eligible for programs operated by the IHS for the benefit of Indians based on their status as Indians by enacting the provisions found at 25 U.S.C. §1679.

*3. California Indian history and eligibility for services based on their status as Indians and being part of the Indian community.*

A very brief history of the treatment of Indians in California helps to understand why Congress has made special provision for serving California Indians because of their status as Indians. When California became joined the Union as a State in 1850, Indian tribes were located throughout the State. Soon after statehood, Federal representatives were sent to California to negotiate treaties with all of the tribes. By the time that those treaties made their way back to Congress to be ratified, as required by law, the gold rush was in full swing. As a result, the treaties were not ratified because the California Congressional representatives did not want to give up any land that might contain gold, as would have been done through the treaties. Toward the end of the 19<sup>th</sup> century in recognition of the severe injustice suffered by the California Indians, provision was made to provide a land base to many of the California Indian tribes, but not all. Reservations and rancherias were established for them through the passage of various federal laws and through Executive Orders. Nonetheless, some tribes remained landless. A number of the tribes who had rancheria lands were later subject to the termination era of the 1950’s. The termination policies had as their goal assimilating Indians into the mainstream culture by terminating their special status as Indians. These tribes had their lands sold off and their assets distributed pursuant to Act of August 18, 1958. Virtually all of the “terminations” were eventually reversed by the Courts or by Congress.

In response to this tragic history of dealings with California Indians, Congress specifically made provision to provide health care services for California Indians because Congress recognized that they were eligible for the special programs and services provided by the United States because they were part of the Indian community and eligible for these services because of their status as Indians.

For a number of reasons, California Indians who are not otherwise members of a federally-recognized Indian tribe meet the definition of being “Indian” because they are part of an organized “group or community” which is “recognized as eligible for the special programs and services provided by the United States as Indians” because of their status as Indians.

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<sup>13</sup> See, also, Rincon Band of Mission Indians v. Harris, 618 F. 2<sup>nd</sup> 569 (9<sup>th</sup> Cir., 1980).

These facts are demonstrated through analyzing the law passed by Congress relating to health services for California Indians. Through 25 U.S.C. §1679, Congress required that health care services be provided to a variety of California Indians. The Indians to be served include:

- (1) Any member of a federally recognized Indian tribe.
- (2) Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant--
  - (A) is living in California,
  - (B) is a member of the Indian community served by a local program of the Service; and
  - (C) is regarded as an Indian by the community in which such descendant lives.
- (3) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.
- (4) Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619) and any descendant of such Indian.

Each of these categories of Indians are eligible for health care services pursuant to the definition of “Indian” both in the IHCA and the ISDEAA because each is an individual who is a member of an “Indian tribe” as that latter term is defined in the ISDEAA and the IHCA, as set forth above.

We shall discuss each category individually and show how the definition of Indian tribe (“an Indian tribe, band, nation, or other organized group or community . . . which is eligible for the special programs and services provided by the United States to Indians because of their status as Indians’) applies to each:

- (1) Members of Federally recognized tribes (25 U.S.C. §1679(b)(1)): These Indians are, by definition, eligible as “members” of “tribes” which requires no further elaboration.
- (2) A descendant of an Indian who resided in California in 1852 (25 U.S.C. §1679(b)(2)): The Indians residing in California at the time of statehood were all members of California Indian tribes, some of which are currently recognized, some of which were suffered through Termination, some of which are in the process of obtaining federal acknowledgment, and some of which have been un-terminated. Despite their differing status, all of these descendants are part of the Indian “community” and are eligible for the “special . . . services provided by the United States to Indians” because of their status as Indians.
- (3)

That individual descendant must be residing in California and “be a member of the Indian community” being served by the Indian Health Service. See, 25 U.S.C. §1679(b)(2)(B). Thus, to be served, these California Indians must be part of an organized “group or community” served by the IHS local program. These California Indians thus meet that portion of the definitional test that requires them to being members of a “tribe. . . or other organized group or community.” If they were not, they would not be eligible to receive services through the IHS.

Finally, the individual must be regarded as Indian “by the community” in which that Indian lives. See 25 U.S.C. §1679(b)(2)(C). Thus they have status as “Indians” as required by the IHCA and the ISDEAA.

Thus, all of the requirements of the definition of Indian as a member of an Indian “tribe,” “group or community” are met as required by 25 U.S.C. Sections 450b(e) and 1603(d) which define Indian tribe. Each California Indian served under this provision must be (1) part of a tribe or organized group or community, and (2) recognized as “eligible for the special programs and services provided by the United States for Indians because of their status as Indians.”

- (4) Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California (25 U.S.C. §1679(b)(3)). Each of these Indians has an interest in land held in trust by the United States for that individual. As such, they are receiving the benefit of services provided by the U.S. because of their status as Indians. Were they not Indians, the land could not be held in trust and administered by the U.S. for that individual Indian’s benefit.
  - (5) Any Indian who was listed on the plans for the distribution of the assets of the California Rancherias and Reservations under the Act of August 18, 1958 and any descendants of such Indian (25 U.S.C. §1679(b)(3)). Virtually all, if not all, of the rancherias and reservations that were terminated under that Act have been reinstated. Thus, the Indians falling under this provision are part of an organized “group or community” which was and is now recognized as eligible for the programs provided by the United States for Indians “because of their status as Indians.” Congress recognized that these individuals are part of the Indian community eligible for services provided by the U.S. for Indians because of their status as Indians when Congress included them as a category of Indians eligible for services from IHS even before their reinstatement.
4. *California Indians have special status in regard to contracting under the ISDEAA, whether or not they are members of Federally-recognized tribes.*

The federal government has recognized the special situation of California Indian in promulgating federal regulations regarding the Indian Self-Determination Act which give California Indian contractors under that Act a special status. The federal regulations implementing the ISDEAA provide at 25 U.S.C. §900.181 that:

Under the ISDEAA, Indian Contractor is defined as follows:

- (1) In California, subcontractors of the California Rural Indian Health Board, Inc., or subject to approval of the IHS Directors after consultation with the DHHS Office of General Counsel, subcontractors of a Indian tribe or tribal organization which are:
  - (i) Governed by Indians eligible to receive services from the Indian Health Service;
  - (ii) Which carry out comprehensive IHS service programs within geographically defined services areas; and
  - (iii) Which are selected and identified through tribal resolution as the local provider of Indian health care services.

Thus, even the implementing regulations for the ISDEAA make it is clear that the California Indians are accorded special status despite the fact that they not be members of federally-recognized tribes as long as they are eligible to receive services from the IHS and carry out the IHS programs within the geographically defined service areas.

Nowhere does the definition of “tribe” in the ISDEAA itself or in the implementing regulations quoted above require that a tribe be a “federally-recognized” tribe. In fact, when it comes to California Indians, the opposite is true. Congress has made it clear that all California Indians who fit one of several categories discussed above, in addition to being federally-recognized, are to receive the special services provided by the U.S. government to Indians because of their status as Indians.

*4. The Canons of Statutory Construction require that laws be liberally interpreted in favor of Indians.*

The U.S. Supreme Court has long recognized that interpretation of treaties, statutes, and executive orders must be liberally construed in favor of the Indians.<sup>14</sup> This principle is a bedrock of Indian law and dates back nearly two hundred years. In addition, all ambiguities in statutes and executive orders are to be resolved in favor of the Indians.<sup>15</sup>

Based on these canons of statutory construction, the law and regulations at issue at present must be construed to allow the maximum benefits of the laws to be provided to

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<sup>14</sup> See, e.g., Choctaw Nation v. United States, 318 U.S. 423 (1943); Worcester v. Georgia, 31 U.S. 515 (1832); etc.

<sup>15</sup> See, e.g., Mc Clanahan v. Ariz. State Tax Commission, 411 U.S. 164 (1973); County of Yakima v. Confederated Tribes & Bands of the Yakima Indian Nation, 502 U.S. 251 (1992); etc.

California Indians. The regulations must thus be drafted to insure that the laws are liberally construed in favor of the inclusion of Indians in general and California Indians in specific.

In summary, NIHB would stress the point that a careful read of the law shows that there is no appreciable distinction between the definition of “Indian” or “Indian tribe” in the IHCIA and the definition of “Indian” in the ISDEAA. Most importantly, neither Act requires that an “Indian” must be a member of a Federally-recognized Tribe. In order to carry out the Congressional intent and to maintain consistency with well-established legal and administrative precedent, eligibility determinations for Indian-specific provisions (such as for payment of premiums, cost-sharing assistance, special enrollment periods, and waiver of penalties for not obtaining qualified coverage) should be based upon the decades of practice by the Indian Health Service and the Bureau of Indian Affairs in applying the definitions contained in the IHCIA and the ISDEAA.

#### **155.260 PRIVACY AND SECURITY OF INFORMATION.**

In the discussion of this section, CMS suggests a requirement that Exchanges “implement some form of authentication procedure for ensuring that all entities interacting with Exchanges are who they claim.”

NIHB cautions that some document requirements **could create barriers for AI/AN**. Some AI/AN are more likely to lack the required documents, and a general distrust of government may cause other individuals to resist requests to provide personal information not specific to the application process. In addition to this note of caution, NIHB urges the inclusion of a provision that would allow AI/AN to designate another individual to represent them in submitting information through the Web site.

#### **155.270 USE OF STANDARDS AND PROTOCOLS FOR ELECTRONIC TRANSACTIONS.**

SUBPART D – RESERVED

SUBPART E – EXCHANGE FUNCTIONS IN THE INDIVIDUAL MARKET: ENROLLMENT IN QUALIFIED HEALTH PLANS

#### **Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans**

Enrollment in QHPs in the Individual Market Exchanges must seamlessly and simultaneously provide both 1) individuals an enrollment process that is simple, user-friendly and protective of personal information, and 2) the ability to handle the complex eligibility determination and enrollment data. Successful operation of this Exchange function rests on the consumer experience and quality control.

#### **155.400 ENROLLMENT OF QUALIFIED INDIVIDUALS INTO QHPs.**

Subsection (b)(1) of this section states that the Exchange must send eligibility and enrollment information to QHP issuers on a timely basis.

NIHB recommends revising the text to read: “the Exchange must send eligibility and enrollment information to QHP issuers on a real time or near real time basis.”

The current language is vague and would allow for unacceptable delays in submitting the qualified individual’s enrollment information to the selected QHP. NIHB’s suggested language addresses this problem.

**155.405 SINGLE STREAMLINED APPLICATION. [CROSS-REFERENCE WITH DEF. OF INDIAN]**

NIHB supports the use a single streamlined application to determine eligibility and to collection information necessary for enrollment for QHPs, advance payments of premium tax credits, cost-sharing reductions, and Medicaid, CHIP, and/or the BHP. This streamlined process will ensure that AI/AN receive the additional AI/AN specific protections and benefits under the ACA, Medicaid, and CHIP. Collecting the correct information regarding AI/AN will also assist with the reporting for FMAP payments.

NIHB recommends codifying an additional requirement to strengthen privacy protections. The rule should state that applicants need not answer questions irrelevant to the eligibility and enrollment process. For instance, an AI/AN individual should not have to answer whether or not the AI/AN individual lives on tribal lands.<sup>16</sup> This information would not affect eligibility or enrollment in Medicaid or CHIP.

**155.410 INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS.**

An adequate initial open enrollment period is critical to ensure Exchange success. NIHB believes the proposed duration of the initial open enrollment period (of five months) is sufficient.

NIHB notes that outreach and education efforts will play a big role in capturing new enrollees. A dedicated public information campaign will also be necessary to inform individuals about coverage and assistance available to individuals.

Related to both of these observation, NIHB stresses the importance of providing adequate notice of the annual open enrollment periods. NIHB recommends including a requirement of 30 day notice before the start of the annual open enrollment.

**155.420 SPECIAL ENROLLMENT PERIODS. [CROSS-REFERENCE WITH DEF. OF INDIAN]**

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<sup>16</sup>See pg. 14 Carol Korenbrot, PhD and James Crouch MPH (December 2010). *American Indians and Alaska Natives: Medicaid State Data Collection for the Centers for Medicare and Medicare Services Tribal Technical Advisory Group (TTAG)*. Retrieved from [http://crihb.org/files/0\\_Medicaid-AIAN-State-Survey-Final-12-8-10.pdf](http://crihb.org/files/0_Medicaid-AIAN-State-Survey-Final-12-8-10.pdf)

§155.420(d)(8) incorporates the statutory requirement of the special monthly enrollment periods in the Exchange for Indians (as defined in Section 4 of the IHCA).

NIHB urges the drafters to retain this provision in the final rule. NIHB advises against requiring a waiting period following enrollment into a qualified health plan, under the special monthly enrollment period for Indians.

Several factors support this position, most notably the practical needs of the AI/AN population and Congressional intent. Congress established the special enrollment period for Indians to address the gaps and differences in health coverage provided by the Indian Health Service, Tribally-operated, and urban Indian health programs. Congress included this mechanism to mitigate the coverage gaps AI/AN regularly experience when they migrate between reservations and between rural and urban areas to access employment or educational opportunities. Requiring a waiting period would defeat the specific Congressional intent regarding AI/AN enrollment and frustrate the general purpose behind the Exchange provisions of the law.

Section 155.420 (f) sets out the limits on changing plans under special enrollment periods. This subsection limits an enrollee's choice to plans at the same level of coverage (i.e., gold, silver, bronze). This restriction is not required by law and should not be imposed by regulation. The discussion explains that a newborn child would have to be enrolled in the same level plan as the parent. However, two parents may have different levels of enrollment, or one or both parents may be ineligible to enroll in an Exchange plan. Furthermore, a new born is not previously enrolled, so enrollment should not be restricted to a particular plan level.

#### **155.430 TERMINATION OF COVERAGE.**

### SUBPART H—EXCHANGE FUNCTIONS: SMALL BUSINESS HEALTH OPTIONS PROGRAM

#### **155.700 STANDARDS FOR THE ESTABLISHMENT OF A SHOP.**

#### **155.705 FUNCTIONS OF A SHOP.**

#### **155.710 ELIGIBILITY STANDARDS FOR SHOP.**

#### **155.715 ELIGIBILITY DETERMINATION PROCESS FOR SHOP.**

#### **155.720 ENROLLMENT OF EMPLOYEES INTO QHPs UNDER SHOP.**

#### **155.725 ENROLLMENT PERIODS UNDER SHOP.**

#### **155.730 APPLICATION STANDARDS FOR SHOP.**

SUBPART I—RESERVED

SUBPART J - RESERVED

SUBPART K—EXCHANGE FUNCTIONS: CERTIFICATION OF QUALIFIED HEALTH

**155.1000 CERTIFICATION STANDARDS FOR QHPs.**

NIHB supports the overall structure of Section 155.1000 and the requirement that Exchange Plans only offer Qualified Health Plans (QHPs) that have been certified by the Exchange. NIHB also supports the establishment of mandatory certification criteria for QHPs. Specifically, we support the inclusion of minimum certification requirements outlined in subpart C of part 156 of the proposed regulations. As discussed below in our comments on that section, we believe that those minimum certification requirements must contain certain Indian-specific provisions in order to ensure that AI/ANs, among the nation's most medically-underserved populations, can meaningfully participate in the Exchanges as intended by Congress.

We also note that in the preamble to the Proposed Rule (at 41891) the Office of Personnel Management (OPM) will enter into contracts with health insurance issuers to offer at least two multi-State QHPs through each Exchange in each State. Pursuant to Federal policy, OPM, as a Federal agency, must consult with Tribes about the selection of such QHPs. NIHB urges OPM to include in the multi-State QHP all I/T/U providers who are willing to participate and to use the proposed Indian health Addendum (discussed in our comments on Part 156) for provider contracts with the QHPs.

Under the Proposed Rule, Exchanges have the option of being active purchasers in a selective contracting process or offering a place on the Exchange to any qualified plan. Research has shown that too many choices can be confusing to consumers and lead to greater consumer dissatisfaction. NIHB advises, for both limited and open Exchanges, that some or all plans include I/T/U providers. Exchanges should also make information readily available and easily searchable so that AI/AN consumers can identify plans that include I/T/U providers.

**155.1010 CERTIFICATION PROCESS FOR QHPs.**

**155.1020 QHP ISSUER RATE AND BENEFIT INFORMATION.**

**155.1040 TRANSPARENCY IN COVERAGE.**

**155.1045 ACCREDITATION TIMELINE.**

**155.1050 ESTABLISHMENT OF EXCHANGE NETWORK ADEQUACY STANDARDS.**

We support the concept in the proposed regulation at §155.1050 that the Exchange "must ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees." This requirement is mandated by Section 1311(c)(1)(B) of the Affordable Care Act. Without more specificity, however, this requirement is insufficient to ensure that AI/ANs will be able to access the Exchanges in any meaningful way. As discussed below in our comments on the network adequacy standards in Part 156, not only are I/T/U providers

required by law to be included in QHPs, but there are compelling policy reasons for including them that benefit both the underserved AI/AN populations and the QHPs themselves.

The network adequacy standards included in the Proposed Rule are insufficient to protect the access of AI/AN to health care in general and I/T/U facilities in specific. Although the preamble to the Proposed Rule provides some elaboration, the only proposed regulatory requirement is that QHPs require a sufficient choice of providers. The preamble invites comments on establishing standards for QHP services areas to be established in a way that does not exclude high utilizing, high cost or medically underserved populations. We learned from experience when States converted their Medicaid programs to managed care, that some managed care organizations whose service area included the entire State assigned AI/AN enrollees to primary care providers in areas that required driving 3-5 hours to access care, while excluding I/T/U providers from their networks. Thus, defining a large service area is not sufficient to assure access to care. Because of market conditions in areas with low population density, there is no way to assure access to care for many AI/AN other than requiring the inclusion of I/T providers in QHP networks. It would help everyone if this was done in a straightforward manner, rather than finding less than satisfactory proxies for this requirement.

➤ [ADD DISCUSSION OF SECTION 408 OF IHCA, EFFECTIVELY REQUIRING AN OFFER TO I/T/U TO PARTICIPATE IN PLAN NETWORKS. REFERENCE DISCUSSION UNDER SEC. 156.230]

The discussion states that “an Exchange may want to consider the needs of American Indians and Alaska Natives residing in remote locations.” While we appreciate the fact that the needs of AI/ANs were recognized in the preamble to the Proposed Rule, this does not go nearly far enough. We believe that the Federal government should take a stronger role. Exchanges may not want to consider the needs of AI/AN for a variety of reasons, including a history of antagonism between State governments and Tribes, exclusion of I/T/U representation on the governing boards of Exchanges, ignorance on the part of State Insurance Commissioners with regard to American Indians and Federal Indian law, and State constitutions and laws that are interpreted to prohibit considering the needs of AI/AN. The U.S. Constitution grants to the Federal government the role of creating Indian policy, and this should not be ceded to State governments or Exchanges. The Federal government has a duty to protect and this duty should be exercised clearly and decisively by HHS through these regulations.

While the discussion section considers the need for a broad definition of primary care for the purposes of network adequacy, this is not reflected in the wording of the proposed regulation. An endorsement of midlevel providers through the example of nurse practitioners is an encouraging start. However, if costs of health care are going to be controlled, there should be payment for a wide range of midlevel practitioner services which have been pioneered through the Indian Health Service, including Community Health Practitioners and Dental Therapists. Particularly as CMS moves forward to use these rules

to design Federally-operated Exchanges in places such as Alaska, these issues should be addressed.

**155.1055 SERVICE AREA OF A QHP.**

**[ADD LANGUAGE DISCUSSING NEED TO ENSURE RESERVATIONS AND AI COMMUNITIES AND THE I/T PROVIDERS SERVING THEM ARE ADEQUATELY INCLUDED.]**

**155.1065 STAND-ALONE DENTAL PLANS.**

**155.1075 RECERTIFICATION OF QHPs.**

**155.1080 DECERTIFICATION OF QHPs.**

**For part 156 of the Proposed Rule -- (p. 41922)**

**B. PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES**

**SUBPART A – GENERAL PROVISIONS**

**156.10 Basis and scope.**

**156.20 Definitions.**

**156.50 Financial support.**

**SUBPART B – RESERVED**

**SUBPART C – QUALIFIED HEALTH PLAN MINIMUM CERTIFICATION**

**156.200 QHP ISSUER PARTICIPATION STANDARDS.**

**[Add specific wording that would allow QHP issuer to enter into contracts with I/T/U that allow for serving AI/AN only and AI/AN preference in employment. And we should note that use of the proposed Addendum protects the QHP, the issuer and the Exchange from charges of discrimination.]**

**156.210 QHP RATE AND BENEFIT INFORMATION.**

**156.220 TRANSPARENCY IN COVERAGE.**

Section 156.220 (d) Enrollee cost-sharing transparency. Information for consumers should accurately portray the special cost-sharing protections for AI/AN.

**156.225 MARKETING OF QHPs.**

**156.230 NETWORK ADEQUACY STANDARDS.**

### Application of and Maintaining Compliance with Section 408 of the Indian Health Care Improvement Act

Including I/T/U providers in Exchange plan networks is required by law. Section 408(a) of the Indian Health Care Improvement Act (IHCIA) requires health care programs that receive Federal funding to accept I/T/U providers. It requires any:

"Federal health care program to accept an entity that is operated by the Service, an Indian Tribe, tribal organization, or urban Indian organization as a provider eligible to receive payment under the program for health care services furnished to an Indian on the same basis as any other provider qualified to participate as a provider of health care services under the program if the entity meets generally applicable State or other requirements for participation as a provider of health care services under the program."<sup>17</sup>

The term "Federal health care program" is defined elsewhere in Section 408 by reference to Section 1128B(f) of the Social Security Act, 42 U.S.C. 1320a-7b(f). The Social Security Act broadly defines "Federal health care program" to include "any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5, United States Code)." 42 U.S.C. §1320a-7b(f). It also includes "any State health care program, as defined in section 1320a-7(h) of this title." *Id.* Under this broad definition, any "plan or program" which provides health benefits "through insurance or otherwise" that is funded directly "in whole or in part" by the United States must include I/T/U providers.

There is no doubt that Qualified Health Plans meet the definition of "Federal health care program" which must accept I/T/U providers under Section 408 of the IHCIA. As a general matter, States have received Federal funds to develop Exchanges, and the Federally-operated Exchanges are also being planned with Federal dollars. Moreover, Federal funds will be used to offer premium assistance in the form of tax credits for people up to 400 percent of the Federal poverty level. As a "Federal health care program," ACA has specific requirements regarding AI/AN that show Congressional intent that AI/AN are to be served by the Exchange plans. For example, the Secretary is directed by law to pay the plans directly to offset the cost-sharing exemptions for AI/AN under Section 1402(d)(3) of the ACA. Section 1402(d)(3) provides that "The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection [the Indian cost-sharing exemption]." Unlike other Federal funds available for the development of Exchanges which have a sunset date,

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<sup>17</sup> We note that Section 408(a)(2) of the IHCIA makes it clear that any licensing requirement imposed by a state will be deemed to have been met by the I/T/U provider if it meets the standards required for licensing regardless of whether a license is obtained, and Section 221 of the IHCIA provides that licensed professionals at an I/T/U facility do not have to be licensed in the state in which they are located provided they are licensed in any state.

the Secretary is directed to provide Federal funding under Section 1402 of the ACA for Exchange plans serving AI/AN in perpetuity. Accordingly, with regard to AI/AN the ACA provides direct Federal funding of the type that results in a mandate that I/T/U providers be included in Exchange plan networks under Section 408 of the IHCA.<sup>18</sup>

The language in Section 408(a) of the IHCA “on the same basis as any other provider qualified to participate as a provider of health care services under the program” means the I/T/U would function like other providers in the network for the QHP. It does not mean that the Federal laws and regulations for AI/AN and the I/T/U would cease to apply. Rather, it is a given that the I/T/U facility would continue to operate as an I/T/U facility while providing services to AN/AN who are enrolled in the plan. Because the I/T/U is unique, contracts that are offered by QHPs would have to be modified to achieve the two objectives of (1) allowing the I/T/U to participate as a provider in a QHP, and (2) upholding the Federal laws and regulations that govern the I/T/U. Based on experience with Medicare Part D, the best way to accomplish these two objectives is for the Federal government to approve a standard amendment that QHPs can use with contracts that are offered to the I/T/U.

#### Creation and Use of an “Indian Addendum” to Exchange Contracts

Setting out applicable Federal law in a single comprehensive Indian contract addendum will reduce administrative cost for States, Exchanges, issuers, and I/T/U facilities rather than duplicate this effort in different settings. The requirements to be included in the I/T/U Contract Addendum include:

- A Tribe or IHS may limit who is eligible for services (without imposing limits on those that may serve individuals who are not eligible for IHS services);
- I/T/Us are non-taxable;
- The Federal Tort Claims Act applies to IHS and Tribal programs, and to those urban Indian organizations that have achieved FTCA coverage through PHS Sec. 224(g)-(n), to eliminate any QHP requirement to carry professional liability insurance or to otherwise indemnify a QHP;

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<sup>18</sup>We also note that elsewhere in the regulations, the Department recognizes that Congress mandated that certain “essential community providers” be included in any provider network. As mandated by the ACA, the Department has proposed that “essential community providers” include the providers defined in Section 340B(a)(4) of the PHS Act, which includes “Federally qualified health care centers,” which is defined in Section 1905(l)(2)(B) of the Social Security Act to include both outpatient health programs and facilities operated by Tribes and tribal organizations under the Indian Self-Determination Act or urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act. Accordingly, tribal facilities and urban Indian organizations must independently be included in provider networks under this provision as well. As discussed in our comments in the next section, we believe that Indian Health Service facilities must also be included as well.

- Employees of the IHS and Tribal programs are not required to hold a license issued by the State in which the program operates as long as they are licensed in any State.<sup>19</sup>
- The IHS and Tribes may exercise Indian Preference in employment decisions per the following authority<sup>20</sup>
- I/T/U health programs are not required to obtain a license from the State as a condition of reimbursement by any Federal health care program so long as the I/T/U meets “generally applicable State or other requirements for participation as a provider of health care services under the program.”<sup>21</sup> “A Federal health care program” means “any plan or that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly in whole or in part, by the United States Government,” including health insurance programs under chapter 89 of title 5; and any State health care program, which includes Medicaid, and CHP, as well as any program receiving funds under certain other provisions of Federal law. Thus, a QHP cannot require licensing in the State as a condition for network provider status nor as a condition for payment for services.
- Special disputes resolution process and recognition of governing law;
- Any medical quality assurance requirements must be subject to new IHCA Sec. 805;
- Compliance with ACA Sec. 1402(d)(2) prohibiting assessment of cost-sharing on any AI/AN enrolled in a QHP
- I/T/Us must be permitted to establish their own days/hours of operation so that any different QHP requirements do not impose barriers to participation
- Nothing in a QHP network provider agreement shall constitute a waiver of Federal or tribal sovereign immunity.

This type of Indian Health Addendum has been used with great success for many years in connection with Prescription Drug Program contracts under Medicare Part D. CMS regulations required Part D plans to offer network contracts to I/T/U pharmacies and include an Indian addendum containing those provisions. These Medicare Part D Addenda have proven to be efficient, effective and easy to use for both Part D plan sponsors and Indian health pharmacies. It is now a standard component of the Part D program.

We were encouraged to see that the Department has solicited comments on special accommodations that must be made when contracting with Indian health providers, and the Department's request for comments on use of a standardized Indian health provider

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<sup>19</sup>IHCA Sec. 221, enacted into law by Sec. 10221 of the ACA.

<sup>20</sup> 25 U.S.C. § 450e(b) and (2) *Morton v. Mancari*.

<sup>21</sup> IHCA Sec. 408(b)(3), as amended, defines “a Federal health care program” by reference to 42 U.S.C. § 1320a-7b(f), which includes “any plan or that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly in whole or in part, by the United States Government.” Sec. 408(b)(3) does not exclude health insurance programs under chapter 89 of title 5. It also includes any State health care program (as defined at 7 U.S.C. § 1320a-7(h), which includes Medicaid and CHP programs, as well as any program receiving funds under certain other provisions of Federal law.

contract addendum for QHP issuers. We believe that the use of such a contract addendum will reduce costs and ease administrative burdens for issuers and ensure meaningful participation by AI/AN in Exchange plans. Indeed, the use of an Indian contract addendum will be critical to achieve both goals.

This direct approach for the Exchange establishment regulations to require that all I/T/U facilities be offered a contract with an approved Indian health addendum is the only way to assure network sufficiency for AI/AN. Sufficient choice of providers is not defined in the Proposed Rule, but it is recognized in the preamble to the Proposed Rule (76 Fed. Reg. at 41894) that there are several components to this, including geographic accessibility, ensuring that a provider is able to deliver the care needed by the insured, and the ability to offer culturally competent care.

Indian hospitals and clinics are located in some of the most isolated, sparsely populated and poverty-stricken areas of the United States. For many Indian people, these hospitals and clinics are their only source of health care. The Bristol Bay Area Health Corporation, for example, is located 329 air miles from the nearest non-I/T/U facility in Anchorage, Alaska. The only way to ensure a "reasonable proximity of participating providers" is for QHPs to offer to contract with I/T/U providers. Given that these I/T/U providers are often the only provider in the area, it is not sufficient for the Federal government to merely state in the preamble to the rule that an Exchange "may want to consider" the needs of AI/AN in remote locations. Unless the Federal government mandates that QHPs include I/T/U providers in their networks, the AI/ANs in these areas may have no in network provider at all.

Geography is not the only barrier to care for AI/ANs, however. In many cases, the I/T/U provider is the only facility with the capacity to serve AI/AN in a culturally competent manner even in areas where other providers may be available. Federal health care is a right long held by AI/AN, and many AI/AN simply will not seek health care from any provider other than an I/T/U provider. Whether because of lack of trust, a history of abuse and discrimination, or because I/T/U providers are the only providers able to offer needed services to their AI/AN populations in a culturally appropriate and competent manner, many I/T/Us will not participate in an Exchange plan unless they can use their I/T/U provider.

AI/AN will benefit from inclusion of I/T/U providers in network in other ways. For example, including I/T/U providers in Exchange plan networks will ensure network access to other providers, and make it more efficient to refer patients to other providers. It will also minimize duplication of services that may result from AI/AN receiving services from in-network and out-of-network providers alike.

Inclusion of I/T/U providers in network will also provide benefit the QHP. Under Section 206 of the IHCA, I/T/U providers have a Federal right to receive reimbursement for

the services they provide whether they are in-network or not. Under Section 206, I/T/U providers have the right to recover the "reasonable charges billed ... or, if higher, the highest amount [a] third party would pay for care and services furnished by providers other than governmental entities..." The Secretary has the responsibility under the Act to enforce this provision. If I/T/U providers are not included in Exchange plan networks, there may be more expensive transaction costs incurred by both the I/T/U provider and the QHP. Alternatively, if the requirement for I/T/U providers to be reimbursed by health plans is not effectively enforced, then the QHPs may realize a potential windfall by collecting premiums for AI/AN enrollees – most likely paid for with Federal dollars – and not making full payment for the health services their Indian enrollees receive from I/T/U providers.

There is no doubt that Congress intended for AI/AN, who are among the most medically underserved populations in the United States, to benefit from full and meaningful participation in the Exchanges. Congress enacted Section 1402(d) of the ACA, for example, which provides that AI/AN whose family income is at or below 300 percent of the Federal poverty level to be protected from any cost-sharing under an Exchange Plan, and AI/AN who receive services at an Indian Health Provider be protected from any cost-sharing regardless of income. These provisions were enacted for the benefit of AI/ANs alone. In addition, the ACA provides general premium assistance to AI/AN and non-AI/ANs alike on a sliding scale to persons whose family income extends from 133 percent of the Federal poverty level to 400 percent of the Federal poverty level. Because an estimated 82 percent of AI/AN are in families with income at or below 400 percent of the Federal poverty level, many could benefit from this incentive as well. These incentives are only available through the Exchange plans and reflect a congressional desire to further the United States' trust responsibility to provide health care services to AI/ANs through the Exchange plans in the ACA.

Several structural barriers must be overcome for AI/AN to take advantage of these provisions, however. There are several key factors that will lead private insurers to have little incentive to seek to enroll AI/AN in their health plans or include I/T/U providers in their networks. First, AI/ANs comprise just one percent of the non-elderly population in the United States. While AI/AN may constitute a majority of the population in some areas, in general they constitute a relatively small percentage of the general population of a Plan's service area.

Second, AI/AN have greater health care needs than the general population and plans would likely avoid enrolling these high risk individuals unless they are required to do so. AI/AN have the highest rate of many health conditions.<sup>22</sup> About 1 in 5 (18%) of AI/AN individuals have two or more chronic conditions. This compares to a rate of 1 in 10 (10%) for non-Hispanic whites. In addition, the prevalence of diabetes among AI/AN (12%) is at least twice that of any other racial and ethnic group, with the exception of blacks (8%).

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<sup>22</sup> Kaiser Family Foundation, "Race, Ethnicity and Health Care, Issue Brief: A Profile of American Indians and Alaska Natives and Their Health Coverage", September 2009, page 1.

AI/AN have higher rates of obesity compared to individuals of any other racial and ethnic group. AI/AN have higher rates of certain behaviors that can negatively impact health. More than one-quarter (27%) of AI/AN are current smokers, which is a higher rate than any other racial or ethnic group.

Third, there is potential pent up demand for needed services in Indian country that would create another disincentive for QHPs to enroll AI/AN. According to a recent Kaiser Family Foundation study, nearly half (47%) of uninsured AI/AN adults do not have a usual source of care, which may make it more difficult for them to receive preventive services and timely care for acute health problems.<sup>23</sup> In addition, the study notes that “[w]hile most adults who only have access to care through the Indian Health Service (IHS) do have a usual source of care, they are about as likely as the uninsured to have had no contact with a doctor or other health professional in the past two years. This is partially the result of budgetary constraints and the IHS system of rationing of care.”<sup>24</sup> Taken together, these factors are likely to result in QHPs either neglecting to take proactive outreach efforts to enroll the AI/AN population or even actively work to avoid enrolling AI/AN. One of the most effective ways for QHPs to ignore AI/AN and discourage their enrollment is to exclude I/T/U providers from their networks.

In order to overcome these barriers, the network adequacy criteria mandated for QHPs must include a requirement that QHPs offer to contract with I/T/U providers with an Indian addendum.

#### **156.235 ESSENTIAL COMMUNITY PROVIDERS.**

We support the Proposed Rule's definition of essential community provider to include all health care providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Act. This is mandated by Section 1311(c)(1)(C) of the ACA. Section 340B(a)(4) of the PHS Act includes "Federally qualified health care centers," which are defined in Section 1905(l)(2)(B) of the Social Security Act to include both outpatient health programs and facilities operated by Tribes and tribal organizations under the Indian Self-Determination Act or urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act. Accordingly, we believe that tribal outpatient health programs and tribal facilities as well as urban Indian organizations should be specifically referenced in the regulations as "essential community providers" QHPs must include in their provider networks.

We also appreciate the fact that the Department "continues to look at other types of providers that may be considered essential community providers to ensure that we are not

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<sup>23</sup> Kaiser Family Foundation, "Race, Ethnicity and Health Care, Issue Brief: A Profile of American Indians and Alaska Natives and Their Health Coverage", September 2009, page 9.

<sup>24</sup> Kaiser Family Foundation, "Race, Ethnicity and Health Care, Issue Brief: A Profile of American Indians and Alaska Natives and Their Health Coverage", September 2009, page 9.

overlooking providers that are critical to the care of the population that is intended to be covered by this provision," and is soliciting comment on the extent to which the definition should include other providers that provide the same services to the same predominantly low-income, medically underserved populations as the providers listed in Section 340B(a)(4) of the PHS Act. 76 Fed. Reg. at 41899. The facilities of the Indian Health Service certainly fit this bill. IHS facilities serve the same populations as tribal facilities and urban Indian organizations, and in many areas of the country where Tribes do not operate facilities under the Indian Self-Determination Act, the IHS facilities are the only facilities serving the AI/AN population. Accordingly, there is no reasoned basis for not including IHS facilities as essential community providers as well.

We take issue, however, with the Department's interpretation of Section 1311(c)(1)(C) of the ACA to only require QHPs to only contract with a subset of essential community providers. In the preamble to the Proposed Rule, the Department states that the Act "does not require QHP issuers to contract with or offer contracts to all essential community providers." 76 Fed. Reg. at 41899. The Department is incorrect in this regard. Section 1311(c)(1)(C) requires QHP issuers to contract with all "essential community providers, where available." The "where available" language means simply that QHPs are not required to contract with essential community providers if no essential community providers are available. If there are no essential community providers in the area, the "where available" language means that QHP plans may be certified without entering into a contract with any essential community provider. It does not "suggest," as the Department states, that QHPs may only contract with a subset of essential community providers. Although we recognize that overarching policy considerations may have led the Department to such an interpretation, it cannot overcome the plain language of the statute.

Even if the Department chooses to maintain this interpretation, I/T/U providers must be included in any "subset" of essential community providers the Department believes QHPs must offer to contract with for all of the policy reasons explained in our comments to the network adequacy standards in Section 156.230 above. Doing so is necessary to ensure meaningful participation by AI/ANs in the Exchanges, and will benefit I/T/U providers and the QHPs equally. I/T/U providers will benefit from inclusion in provider networks, and QHPs will benefit from the safe harbor offered by the Indian Addendum and up front inclusion of the payment requirements of Section 206 of the IHCA, which the Department correctly recognizes applies to QHPs.

In the discussion portion of the Proposed Rule, the rationale provided for not requiring that contracts be offered to all ECPs is that "such a requirement may inhibit attempts to use network design to incentivize high quality, cost effective care by tiering networks and driving volume towards providers that meet certain quality and value goals." It should be noted that AI/AN populations are so small that it makes no sense to consider "driving volume" toward providers. While this rationale may have merit in areas where there are competing facilities, it does not apply to remote rural and tribal areas where market forces do not operate in the way described. Geographic access to care is a

fundamental issue that must be addressed before one can consider lowering costs or increasing profits for issuers. Furthermore, cultural competency must be considered as a component of quality.

Although Congress included important incentives for AI/AN to participate in Exchange plans, discussed in the previous section on network adequacy, those incentives alone will not be sufficient to overcome several significant structural barriers to meaningful AI/AN participation in the Exchanges. In order to assure that AI/ANs can meaningfully participate in the Exchanges, the Federal regulations must require QHPs offer to contract with I/T/U providers using an Indian health Addendum.

#### **156.245 TREATMENT OF DIRECT PRIMARY CARE MEDICAL HOMES.**

#### **156.250 HEALTH PLAN APPLICATIONS AND NOTICES.**

The ACA requires the Secretary to develop and provide to each State a single, streamlined form for enrollment. The discussion states that this application is being “developed by HHS with recommendations from the NAIC.” While the National Association of Insurance Commissioners should be consulted in the development of the application, Tribes should also be consulted. With variations in the definition of Indian for Exchanges and Medicaid, it is important to have a system that integrates the provisions and protections for AI/AN in the most simple and straightforward manner. NAIC does not have experience dealing with Indian health and Indian law and should not serve as experts in this aspect of application development.

#### **156.255 RATING VARIATION.**

#### **156.260 ENROLLMENT PERIODS FOR QUALIFIED INDIVIDUALS.**

#### **156.265 ENROLLMENT PROCESS FOR QUALIFIED INDIVIDUALS.**

Section 156.265 (e) Enrollment information package. In addition to a general information package, it would be helpful for AI/AN to have a special enclosure that explains their specific benefits and how to access them. It might be confusing to insert this in the publication that goes to the general public. Nothing in the regulations prohibits this.

Section 156.265 (e) Summary of benefits and coverage document. This document should contain specific information for AI/AN.

#### **156.270 TERMINATION OF COVERAGE FOR QUALIFIED INDIVIDUALS.**

#### **156.275 ACCREDITATION OF QHP ISSUERS.**

#### **156.280 SEGREGATION OF FUNDS FOR ABORTION SERVICES.**

We are pleased that the Proposed Rules do not exceed the restrictive statutory language of §1303 related to abortion coverage. However, we urge clarifications of several parts of the proposed rule so that abortion coverage may remain in private health insurance and so that consumers will not be deterred from enrolling in the plan best suited to their needs.

Under the current system of employer sponsored health insurance, many plans offer coverage of abortion services. This benefit is critical to women who cannot afford to pay out of pocket for an abortion procedure on top of the premiums and other cost sharing they may already expend towards their health care needs. Women who require abortion care may be forced to wait until later in their pregnancies for financial reasons if the service is not included in their insurance plan. Many AI/AN women already face barriers to reproductive health care such as geographic isolation, cultural stigma related to sexual health, domestic violence, and lack of basic health insurance coverage. For these women, maintaining insurance coverage of abortion services is essential. These issues are compounded for persons with limited English proficiency, who may not understand that abortion care can be provided safely and legally in the United States if abortion care is inexplicably segregated from their health care coverage.

§156.280(c) Voluntary choice of coverage of abortion services. Consistent with §1303 of the ACA, QHPs have the option to include abortion coverage in their plans. For these reasons, we recommend that §156.280 make clear that a QHP is neither required nor prohibited from including abortion services for which public funding is prohibited, in the absence of a state law barring such inclusion, and so long as the QHP is in compliance with the applicable provisions of the ACA.

§156.280(e)(2) Establishment of allocation accounts. The ACA prohibits the use of Federal funds to pay for abortions for which public funding is prohibited, if a QHP opts to include those services in the benefit package. The Proposed Rule should make clear that the insurance plans, not the enrollees, are responsible for segregating the funds that cover the portion of the premium for abortions for which public funding is prohibited. The term “separate payment” in §156.280(e)(2)(i) should be interpreted as allowing individuals to make their separate payments in one transaction and/or in one instrument. This will ensure that the funds are maintained separately without placing the burden of producing payment by two transactions or instruments on the enrollee. Requiring two separate transactions or instruments would ultimately compromise the streamlined process with which the ACA endeavors to make coverage accessible and available to consumers. We urge CCIIO to make clear that insurers can meet this requirement by collecting the funds in the same transaction or instrument by submitting an itemized bill to the enrollee. An itemized bill would delineate the portion of the funds to be used for abortion coverage and for other coverage. This practice is standard in the insurance industry, for example, when a consumer purchases auto and homeowners insurance from the same carrier, and can pay the entire insurance bill in one transaction.”

§156.280 (f) Rules relating to notice. Notice of coverage, and subsequent changes in coverage, should be made accessible for those who have limited English proficiency (LEP). Language access is one aspect of cultural competence that is essential to quality care. We recommend CCIIO incorporate our suggestions in §155.230 regarding notice requirements. QHPs must ensure that their members understand what services are covered under the plan purchased. If there are changes to the plan, QHPs must be responsible for ensuring that members understand those changes.

**156.285 ADDITIONAL STANDARDS SPECIFIC TO THE SHOP.**

**156.290 NON-RENEWAL AND DECERTIFICATION OF QHPs.**

**156.295 PRESCRIPTION DRUG DISTRIBUTION AND COST REPORTING.**



To Whom it May Concern:

According to the directions given below, we are submitting some written comments on the State's request for input regarding Health Benefit Exchanges in Minnesota. Please let me know, if you have any questions or if you are interested in discussing these concepts in more depth. Thank you!

Leigh Ann Newman



**Leigh Ann Newman**  
509-254-2603 tel, 509-254-2613 fax  
200 Fair Street, Clarkston, WA 99403  
PublicConsultingGroup.com

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**From:** Niemi, Alison M (DHS) [<mailto:alison.niemi@state.mn.us>]  
**Sent:** Tuesday, October 11, 2011 12:17 PM  
**To:** Newman, Leigh  
**Subject:** RE: Request for Comment Regarding Exchange Proposed Regulations

Hello- Please send written comments to [HealthBenefit.Exchange@state.mn.us](mailto:HealthBenefit.Exchange@state.mn.us) and write "Exchange" in the subject line of the email. Thanks. Let me know if you have any questions.

**From:** Newman, Leigh [<mailto:lanewman@pcgus.com>]  
**Sent:** Tuesday, October 11, 2011 11:59 AM  
**To:** Niemi, Alison M (DHS)  
**Cc:** Paterson, Janice; Forrer, Fred; Coakley, Patrick  
**Subject:** RE: Request for Comment Regarding Exchange Proposed Regulations

Hello Alison,

We appreciate you forwarding on DHS' request for comments on the establishment of Health Benefit Exchanges in Minnesota. As part of our work for health care reform clients, Public Consulting Group (PCG) has reviewed the notices of proposed rulemaking (NPRM) and provided insight and recommendations for comments. For example, for the proposed rule Exchange Functions in the Individual Market; Eligibility Determinations; Exchange Standards for Employers (CMS-9974-P) PCG identified some of the following areas where the State may wish to provide comments and recommendations to CMS:

**Exchange eligibility standards** – *State may wish to comment on the standard for residency. Specifically, Medicaid has adopted a number of additional rules regarding residency for special populations, including institutionalized individuals, individuals receiving Title IV–E payments, individuals receiving State supplementary payments, individuals incapable of expressing intent, and emancipated minors. In paragraph (a)(3)(iii) of this section, CMS proposes that the Exchange follow these Medicaid residency*

*standards (which are proposed in the Medicaid proposed rule at 42 CFR 435.403) and the policy of the State Medicaid or CHIP agency to the extent that an individual is specifically described in that section and not in paragraphs (a)(3)(i) or (ii). CMS is looking for comment regarding how to be sure Medicaid, and CHIP can reach a definition or set of definitions of residency that will enable a uniform eligibility determination process for the vast majority of individuals to reduce complexity and confusion for all involved parties.*

**Exchange reconciliation process** - *The Exchange will be responsible for reconciling the information provided regarding income and eligibility for premium tax credits and cost sharing reductions. There are concerns regarding the potential for the reconciliation process, in combination with the annual basis of household income for advance payments of the premium tax credit, to render coverage unaffordable for individuals who have substantial decreases in income during the benefit year. A related concern is that the fear of large repayments due to reconciliation after an increase in income could deter enrollment. Both effects could result in a lower participation and a negative impact on the Exchange risk pool. To address these concerns, the Exchange can decrease the difference between the amount of advance payments and the premium tax credit amount based on actual income at the end of the year through a strong initial eligibility process that maximizes accuracy and a strong process by which individuals can report changes that occur during the year. CMS seeks comments on ways of achieving this outcome.*

**Verification for individual eligibility for the Exchange process** - *In general HHS is relying on sources of electronic data, and if not able to verify through such sources, then request documentation from the applicant. Federal Data sources may include SSA, Dept of Homeland Security and IRS. The proposed regulation supports the use of the DHS Systematic Alien Verification for Entitlements (SAVE) system and is what HHS plans to use. Does the proposed process provide the State with sufficient data verification opportunities? Are there other data sources the State may consider appropriate that HHS has not proposed? Will the State be able to verify applicant information in State tax returns? Information from TANF? Motor vehicles? Does the State require additional federal rulemaking authority or does the State need to complete additional state rulemaking to be able to share data sources not considered by HHS? The proposed regulation does not provide enough guidance to States regarding how to verify applicant attestations.*

This information is provided as a service to our clients, and there are other areas within this proposed rule that the State may wish to comment. PCG has also reviewed the other NPRMs and has completed a similar set of analyses. Please let me know if you would like any additional details or information regarding our health care reform work. We would be happy to set up a call to discuss these issues in more detail. Thank you.

Leigh Ann



**Leigh Ann Newman**  
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**From:** Niemi, Alison M (DHS) [<mailto:alison.niemi@state.mn.us>]  
**Sent:** Friday, September 30, 2011 8:09 AM  
**Subject:** Request for Comment Regarding Exchange Proposed Regulations

FYI

Dear Community Partners,

The Minnesota Departments of Commerce, Human Services and Health are requesting comments regarding proposed rules and requests for information that were issued by the U.S. Department of Health and Human Services (HHS) regarding the establishment of a Health Benefit Exchange. The Departments will use the comments to enhance its understanding of the impact of the proposed regulations on stakeholders and will help inform the Departments' responses to DHHS. We are specifically seeking comments on:

Proposed Rules:

1. Establishment of Exchanges and Qualified Health Plans (CMS-9989-P)
2. Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-P)
3. Exchange Functions in the Individual Market; Eligibility Determinations; Exchange Standards for Employers (CMS-9974-P)
4. Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010 (CMS-2349-P)
5. Health Insurance Premium Tax Credits (REG-131491-10)

These proposed regulations can be found on the Center for Consumer Information and Insurance Oversight (CCIIO) website:  
<http://cciio.cms.gov/resources/regulations/index.html#hie>. (Scroll down to "Affordable Insurance Exchanges".)

Request for Information:

1. Basic Health Program

This request for information can be found on the CCIIO website:  
<http://cciio.cms.gov/resources/comments/index.html>.

Comments are requested to assist the Departments in preparing a formal response to HHS. Please see the attached for additional details and specific questions.

Comments are requested on or before 3pm central time on Tuesday, October 18, 2011. Send written comments to [HealthBenefit.Exchange@state.mn.us](mailto:HealthBenefit.Exchange@state.mn.us) and write "Exchange" in the subject line of the email.

Please contact Carley Barber, Exchange Project Manager with any questions, email: [carley.barber@state.mn.us](mailto:carley.barber@state.mn.us), phone: 651.296.6576.

Thank you.

**Karen Gibson**

Director, Health Care Eligibility & Access Division  
Minnesota Department of Human Services

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Dear Commissioners of DHS, MDH, and Commerce:

In 1994 in Minnesota the State Legislature passed legislation that mandates health plans contract with Essential Community Providers (ECP) in the communities in which they do business, *see 62Q.19*. The Minnesota State Legislature was the first to pass the Clinton Administration's concept of ECP and faced strong opposition from the health plans at the time. Immediately following the passage of ECP in Minnesota, contractual relationships between Planned Parenthood Minnesota and health plans were made for family planning services, thereby significantly increasing access to needed reproductive health care for thousands of Minnesota women and their families. While some politically-motivated opposition to some providers of women's health care continued for a number of years after the enactment of ECP in Minnesota, no significant changes were made to the law affecting women's health care providers. Prior to the passage of ECP in Minnesota the state health plans contracted with Planned Parenthood for abortion services, but often did not contract for all the other essential women's health care services that Planned Parenthood provides. Under Minnesota law health plans must contract with the ECP for all the covered benefits they provide.

Under the Affordable Care Act, health plans participating in health insurance exchanges must include essential community providers (ECPs) within networks. Congress included this provision in order to ensure that patients actually have access to health care—not just insurance coverage.

Consistent with the health care reform statute, the proposed HHS rule identifies two categories as ECPs: 340B providers and what we call 340B “look-alike” providers. The 340B “look-alike” category is a direct reference to a part of the law for which the legislative history shows was established specifically for family planning clinics. Given this—and the legislative history around the ECP provision itself—it's clear that Congress was especially concerned about women's access to care.

#### THE CONCERN:

HHS reiterated the above two categories in the proposed rule; however, the proposed rule requires health plans to contract with a “*sufficient*” number of ECPs, instead of all ECPs. HHS is accepting comments on what “sufficient” should mean. *Due to the history of the provision – and women's unique challenge in accessing care – “sufficient” for women's services should include **all women's health care clinics or family planning clinics***. Allowing the proposed rule to stand would gravely harm the viability of Planned Parenthood clinics throughout the country as politically-motivated opposition would ensure that health plans avoid contracting with Planned Parenthood affiliates and their clinics. By excluding Planned Parenthood from contracts with health plans offered through the exchange, thousands of women throughout the country, and in Minnesota, would have health insurance but limited access to trusted, confidential and high-quality reproductive health care services.

Unless the word ‘sufficient’ includes all women's health care clinics or family planning clinics, the proposed rule would limit Minnesota's women and their families' access to high-quality reproductive health care. Too often women have health insurance coverage but are unable to access women's health providers, like OB/GYN practitioners and women's health centers. When health insurance coverage expands to a larger number of Americans, women's health

providers are often the first to be overwhelmed with the increased demand. Our own Minnesota experience prior to the enactment of the Minnesota ECP statute illustrates that without a state mandate Planned Parenthood could not get the majority of health plans to contract for family planning services, thus limiting Minnesota women's access to health care providers statewide.

As HHS works to implement the ECP provision, special protections should be put in place for access to essential community providers that focus on women's care, like family planning clinics and women's health centers. This would be consistent with a long line of existing protections for women's access to OB/GYN care. Like it is under Minnesota law, it's also important that HHS require that health plans contract with essential community providers for all of the covered benefits they provide.

Lastly, it is also important that the final rule makes it clear that private health insurance plans participating in the exchange would still be able to offer comprehensive coverage as they do today.

Sincerely,

Sarah Stoesz  
Sarah Stoesz  
President/CEO  
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**Comment Form**

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

**Federal Register, Vol. 76, No. 136, page 41866, July 15, 2011**

Organization Name: UCare Minnesota  
 Contact Person's Name: Stephanie Schwartz  
 E-mail: [sschwartz@ucare.org](mailto:sschwartz@ucare.org)  
 Telephone #: 612-676-3632

No.	Fed. Reg. Page and Regulatory Cite	Description of Issue or Question	Suggested Revision/Comment
1.	FR 41872; §155.100	Regulations inside and outside the Exchange	As an overall comment applicable to several proposed provisions, UCare believes that, for a health benefit exchange to provide a competitive, stable marketplace, it is imperative that HHS does not create opportunities for different regulation of plans inside and outside the exchange. This is a particularly important concept for a health plan organization, such as UCare, which focuses on public program business and does not offer individual or group commercial plans.
2.	FR 41870; § 155.105 (f)	Federally-facilitated Exchange	UCare supports the concept of a federal/state partnership approach, but believes any partnership must support local plan participation, local plan engagement and consultation, as well as recognize local market conditions.
3.	FR 41872 §155.110(c)(2)	Exchange public meetings	The final rule should address that not <u>all</u> meetings should be open to the public. For example, if dealing with an Exchange employee issue, or if reviewing issuer proprietary information or an individual enrollee's PHI, the Exchange board should be able to close portions of the meeting. State "sunshine" or open meeting laws may be instructive here.
4.	FR 41872; § 155.110(c)(4)	Exchange governing board	To more clearly show HHS' intent, we suggest that § 155.110(c) (4) be revised to state " <u>at least</u> " a majority of the voting members on its governing board have relevant experience in the various areas.
5.	FR 41873; § 155.110(e)	Exchange and SHOP governance	We understand that for administrative efficiencies a state might wish to house both Exchanges under the same governance or administrative structures. We can support that arrangement provided there are separate portals or administrative units to address the differing requirements of the individual and SHOP exchanges, and to reflect the potential for different marketplaces with varying issuer participation.
6.	FR 41873; § 155.130	Stakeholder consultation	We support consultation with issuers as a key stakeholder in Exchange operations. More specifically, we recommend that the reference in (j) to Health insurance issuers be amended with the addition of the words "including local health insurance issuers". Such a distinction is critical so

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**Federal Register, Vol. 76, No. 136, page 41866, July 15, 2011**

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<b>No.</b>	<b>Fed. Reg. Page and Regulatory Cite</b>	<b>Description of Issue or Question</b>	<b>Suggested Revision/Comment</b>
7.	FR 41877; §155.210	Role of Brokers as Navigators	<p>that multi-state issuers do not end up dominating stakeholder consultations as the primary representatives of health insurance issuers.</p> <p>1. The ACA mentions licensed insurance agents and brokers as eligible entities that may be navigators subject to meeting the standard established by the Secretary. The ACA also makes clear that a navigator shall not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a qualified employer in a QHP. Clarity is needed as to whether an individual may serve concurrently as both a navigator who receives no consideration and a broker/agent who may receive consideration from a health issuer? If the answer is that an individual can perform both roles concurrently, additional clarity and guidance in the rule is needed to distinguish how conflicts of interest are to be avoided in this circumstance, and how this information is to be disclosed to consumers.</p> <p>2. In describing the duties of a navigator, the ACA consistently makes reference to qualified health plans to the exclusion of public plans or programs. However, the ACA appears to also envision that the Exchange will provide a "no wrong door" access point for consumers regardless of income or eligibility for public programs. Thus, it will be important for navigators to have experience and understanding of the eligibility and enrollment process in public programs. The rule should be more clear that navigators will provide information about Medicaid, including Medicaid health plans, rather than general reference to "other programs" in 155.210 (c) (2).</p> <p>3. Overall, in light of the potential for confusion regarding the roles of brokers and navigators, we recommend that HHS issue, as</p>

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			<p>part of the final rule or as interim guidance, scenarios or "Q &amp; A's" that clarify their roles with respect to reimbursement, enrollment activity, scope of agency or representation, and licensure or certification.</p>
8.	FR 41878-79; §155.240	Premium aggregation in the SHOP Exchange and Individual market.	<p>UCare strongly supports the provision in paragraph (c) of the ability of employer to submit aggregate premium to SHOP Exchange. Specifically, for new entrants into the Exchange such as the many Medicaid health plans without prior group experience, it should be noted that premium aggregation is considered a <u>preferred</u> option for Exchanges. Additionally, the final rule should expressly grant state exchanges the flexibility to explore premium aggregation in the individual market as well. Premium aggregation must be closely coordinated with the subsidy process</p>
9.	FR 41881; §155.400 (b) (1)	Enrollment of qualified individuals: Timing of data exchange	<p>The language in this section requiring the Exchange to send eligibility and enrollment information to QHPs on a "timely basis" is vague, subject to interpretation and disputes, and likely to lead to processing delays and frustrated consumers. Instead, the final rule should include a requirement that enrollment transaction information be transmitted from the Exchange to the QHP on a real-time basis, or at least once every 24 hours.</p>
10.	FR 41881; § 155.405	Single streamlined application	<p>As a Medicaid health plan issuer concerned about disruption and churn for low-income individuals, we strongly support a single streamlined application for Medicaid and Exchange subsidies, and request that the final rule continue to advance this important policy.</p>
11.	FR 41833; § 155.410	Automatic enrollment of Individuals receiving premium tax credits	<p>The NPRM seeks comments regarding whether to require Exchanges to automatically enroll individuals who received advance payments of the premium tax credit and are then disenrolled from a QHP because the QHP is no longer offered if such individual does not make a new QHP</p>

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		<p>Open enrollment period overlap with Medicare Advantage</p>	<p>selection.</p> <p>While automatic enrollment to a default plan may be a relatively low cost administrative function for the Exchange to implement, the primary consideration should be the consumer's preference. Rather than automatic enrollment into a default health plan that may or may not meet the consumer's needs, we recommend that, in cases where the QHP is closed due to merger or other circumstances, a special enrollment period is triggered to allow the individual the opportunity to choose a QHP, thereby preserving a principle tenet of the ACA.</p> <p>Finally, the proposed initial open enrollment period extends from October 1, 2013 through February 28, 2014. Then in subsequent years, the open enrollment period will be October 15 through December 7. It should be noted that in both instances, the proposed open enrollment periods will overlap with the Medicare Open Enrollment Period of October 15 through December 7. Additionally, Minnesota schedules its fall open enrollment period for state programs from early October through December 15<sup>th</sup>. Together, this considerable overlap of enrollment periods will create an administrative burden for local health plans as a new entrant into the commercial market. This overlap will result in substantial short-term staffing requirements for local plans. The potential also exists for seniors to get confuse the exchange open enrollment period with the Medicare open enrollment period. We recommend that alternative options be explored to reduce overlap and the potential for consumer confusion.</p>

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12.	FR 41866 §155.720 (a)	Enrollment of employees into QHPs under SHOP.	Paragraph (a) states that all references to QHPs in this section refer to QHPs offered through the SHOP. However, clarity is needed in the final rule that issuers do <u>not</u> have to participate in <u>both</u> the SHOP and Individual Exchanges. It should be noted that § 156.285 sets forth additional standards specific to QHPs in the SHOP. The rule appears to envision that there could be different QHPs in the SHOP than in the individual exchange, implying different issuer participation. We request that this be made more clear, particularly as states begin determining participation rules in marketplaces with successful Medicaid health plan issuers that may not be well positioned for participation in a SHOP Exchange.
13.	FR 41921 § 155.1055	Service area of a QHP	This section requires the Exchange to establish the service area of QHPs to determine whether minimum criteria are met including the minimum geographical area. Clarity in the final rule is requested to confirm that issuers can offer QHPs to a portion of the individual market within a geographic area, such as offering QHP's just to individuals receiving subsidies. For an issuer focused on Medicaid plans, serving those individuals in the Exchange who may move on and off Medicaid and QHP's would allow such issuers to leverage their expertise and provide unique value without requiring them to make investments to compete in a new market segment.

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14.	FR 41887; §155.705 (b) 4	Functions of a SHOP	We emphasize our support for premium aggregation in the SHOP and recommend that Exchanges be given the flexibility to perform premium aggregation in the individual exchange.
15.	FR 41919 §155.705 (b) 7, 8	QHP availability in merged markets	We support permitting states to merge the individual and small group market risk pools. Merging markets can stabilize premiums and allow one exchange to serve both individuals and small businesses. This has the advantage of substantially increasing its potential enrollment volume, promoting more robust competition among insurers within an exchange, and achieving economies of scale that can keep an exchange's administrative costs low.
16.	FR 41891; §155.1000	Certification standards for QHPs	We do not support the implementation of additional selection criteria beyond the federal minimum QHP certification standards. Additionally, we do not support a test based on whether a health plan is considered in the interest of the qualified individual and employers.

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17.	FR 41893; §155.1045 & FR 41925 § 156.275	Accreditation timeline	We request that the final rule permit Exchanges to accept Medicare Advantage or Medicaid participation by an issuer as accreditation. For issuers with a successful track record in these programs, the expense and limited value of private accreditation may affect their participation, and deprive the Exchange of consumer choice. Deeming compliance with the Exchange accreditation requirements through Medicare Advantage participation makes particular sense. HHS already recognizes that Medicare Advantage and private accreditation have similar performance standards, and has deemed compliance with Medicare Advantage standards through private accreditation under 42 C.F.R. 422.156. In the alternative, we strongly support the proposed grace period of two years from date of QHP certification for a QHP issuer to become accredited.
18.	FR 41893; §155.1050	Establishment of Exchange network adequacy standards	We support the state's ability to have exchanges use state network standards to ensure uniform regulation in exchange and non-exchange markets.
19.	FR 41899; §156.235	Essential Community Providers	We support flexibility in contracting with ESPs; specifically, the final rule should clarify that health plans are able to exclude from their network providers who cannot demonstrate quality health care delivery and meaningful access to enrollees. Greater specificity on the definition of "sufficient" is unnecessary given the network adequacy requirements for QHPs.

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20.	FR 41900; § 156.235	Payments to Federally Qualified Health Centers (FQHCs)	We recommend that issuers contracting with FQHCs have flexibility in setting payment rates that are commensurate with local market conditions and not limited to prescribed formulas based on Medicaid payment rates.
21.	FR 41900; § 155.230	General standards for Exchange notices	We recommend that the final rule be explicit in allowing the Exchange the flexibility to offer enrollment materials in multiple formats, including electronic notification.

Dear Departments of Commerce, Human Services and Health,

I am a family physician who spent a year buying a new health insurance policy every month on the private market in order to help my patients. Thank you for your invitation to give input on the MN health insurance exchange. Below are three simple principles that would help assure that competition in the insurance market benefits all participants.

1. **Build a Level Playing Field** – Most consumers are not risk management experts. While insurance companies employ small armies to help assess the risk vs. cost of the products they offer. Consumers who use the market aren't similarly equipped to make these decisions. If the market is to succeed in improving quality and lowering cost we have to make it easier for consumers to assess which product offers them the best level of coverage for their dollar.

As insurance providers shift more costs onto consumers and insurance policies are more riddled with holes assessing the true benefit offered by any given policy becomes challenging. The typical approach of comparing the individual features like monthly premium, deductible, benefit set, out of pocket max etc. can become dizzyingly complex. Consumers need to understand the differences in the policies they're buying and most importantly they need to understand the financial liability that accompanies each product.

In other words, the consumer needs to understand effect a product will have on their health care costs. Providing the consumer with a *total cost-to-use* estimate, which considers the expense of the monthly premium, the annual out of pocket costs and any coverage exclusions would be a helpful tool. This total cost-to-use estimate could be calculated in three different scenarios: the cost-to-use in the case of typical health maintenance, the cost-to-use in the case of a chronic illness and the cost-to-use in the case of a catastrophic illness. Plans could be ranked based on their level of coverage in those three situations and then consumers would be able to estimate how much personal expense they can tolerate and be able to plan ahead accordingly.

2. **The Prize Must Be Worth Competing For** – Individual mandate or not, 43 million new Americans will not buy health insurance products that are poor quality. As debate rages about an “essential benefit set”, the one essential feature that every health insurance policy on the market should have is ironclad catastrophic coverage. Protection from bankruptcy due to a catastrophic medical event is something that no Minnesotan should have to go without and every Minnesotan can understand the need for. Financial protection from such unforeseeable events is the original

function of the insurance industry and in the case of health insurance, establishing ironclad catastrophic coverage as a minimum requirement will result in a product people see the point in buying. As the least common denominator of every policy no one “insured” through the exchange will go bankrupt due to a policy that covers only a certain percent of catastrophic cost or one that has a cap. Since consumers are mandated to buy this product let’s make sure it’s basic functioning is sound.

3. The Contest Can’t Be Rigged – Simply setting up the exchange doesn’t guarantee consumers will be able to exert enough pressure to improve quality and cost. There is a clear national mandate for consumers purchase a health insurance policy but no similar mandate for the quality and affordability of the policies that insurers offer. The state should keep tabs on the market and if quality and affordability aren’t improving they should intervene.

Keeping score is important. While competition for the consumer dollar is the basic premise of the exchange, we should also consider the competition between states to have the best health care in the nation and the nation to have the best health care in the world. If Minnesota’s health insurance market isn’t improving in it’s national or international rankings we need to find ways to improve competition. We can learn from better performing private and public programs and we can support developing innovative new products and we can find new ways to help consumers make good decisions.

Please let me know if I may be of further service in your efforts.

Sincerely,

Will Nicholson M.D.  
[triagepolitics.com](http://triagepolitics.com)