

**COMMENTS to the Department of Health and Human Services,
Centers for Medicare & Medicaid Services**

**RE: Proposed Rule on Patient Protection and Affordable Care Act:
Establishment of Exchanges and Qualified Health Plans
CMS-9989-P**

by

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The League of Women Voters of Tennessee and the League of Women Voters of the United States offer the following comments on the Department of Health and Human Services' proposed rule on the Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans (RIN 0938-AQ67), published in the July 15, 2011 *Federal Register* (45 CFR Parts 155 and 156).

Established in 1920, the League of Women Voters is strictly nonpartisan; it neither supports nor opposes candidates for office at any level of government. At the same time, the League is wholeheartedly political and works to influence public policy through advocacy. It is a grassroots citizen network directed by the consensus of its members, in 800 state and local Leagues nationwide. The League of Women Voters of Tennessee (LWVTN) has chapters in all three Grand Divisions of the State. Its policy positions are consistent with those advocated by the LWVUS.

Over time, the League's advocacy priorities change to reflect the needs of society and critical issues of concern. The organization remains true to its basic purpose: to make democracy work for all citizens. The League of Women Voters researches issues from many points of view, forming positions and taking action on those important to the greater good of their communities, locally and nationally.

The League believes that quality, affordable health care should be available to all U.S. residents. It considers the Patient Protection and Affordable Care Act (ACA) an important first step toward achieving needed reform of the health care system in the United States and supports its implementation nationwide, with ongoing efforts to assess and improve the efficacy and fairness of programs developed to implement this law.

In particular, the League supports programs aimed at decreasing the number of individuals who lack health insurance, including: expansion of Medicaid eligibility; development of group insurance pools for uninsured individuals and small businesses, with special attention to the protection of individuals with chronic and/or complex health problems who are poor, disabled, or medically underserved; and establishment of a fair reimbursement system for providers of health services to such individuals.

Comments on the Proposed Rule

Thank you for the opportunity to submit comments on the proposed rule on the Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans. We strongly support efforts to improve choice of affordable health insurance through the Insurance Exchanges and to provide a seamless application and enrollment process for individuals who qualify for health plans offered through the Exchange or public programs.

Our overarching concern about the proposed rule is that by allowing states too much flexibility in implementing an Exchange, it may exacerbate health care access barriers for the growing number of uninsured individuals in the United States — especially for those with limited resources and chronic or disabling health conditions. We fear that people living in states that choose not to implement an Exchange in a timely manner or with appropriate consumer protections will bear disproportionate health and financial risks.

The following comments and recommendations focus on six issues discussed in the NPRM:

1. Exchange Governance Standards
2. Navigator Program Standards
3. Eligibility and Enrollment
4. Interface between Medicaid and Exchanges
5. Preventing Adverse Selection
6. Federally-facilitated Exchanges

- 1. Exchange Governance Standards:** We agree that it is essential to foster transparent decision making by Exchange boards, minimize conflicts of interest among their members, and require Exchanges to consult regularly with stakeholders, including health care consumers and their advocates — as discussed in sections 155.110(c)(2), 155.110(d)(1), 155.110(d)(2), 155.110(c)(3), 155.110(c)(4), and 155.130. Exchanges should be governed in accordance with standards of transparency and public accountability to insulate them from undue commercial or political pressure.

LWVTN & LWVUS believe the regulations could better protect consumer interests in the following ways:

- **Prohibit anyone who benefits financially from the sale of particular health insurance plans offered inside or outside an Exchange from serving on the Exchange board.**
 - **Require that a majority of voting Exchange board members represent consumer interests (be recipients of health coverage offered through the Exchange or their advocates).**
 - **Require Exchanges housed within a state agency or a quasi-governmental agency to have a Consumer Advisory Committee comprised of consumer advocates and non-profit organizations with relevant expertise.**
- 2. Navigator Program Standards:** Navigators should include trusted community organizations to best help consumers select an affordable, quality health plan; facilitate enrollment; refer enrollees to consumer assistance programs for help with grievances or appeals; and/or provide information in a culturally and linguistically appropriate manner— as discussed in sections 155.210(b)(1)(iii), 155.210(d)(1), 155.210(b)(1)iv), 155.210(c)(2), and Overview, pp. 46–47.

LWVTN & LWVUS believe the regulations could better protect consumer interests in the following ways:

- **Explicitly prohibit states from requiring Navigators to be licensed as brokers.** Licensure required for insurance brokers and agents would not assure competence at all tasks required of Navigators for all covered populations. Community-based organizations that currently facilitate enrollment in Medicaid and CHIP are models for how unlicensed Navigators might work.
 - **Require states to designate at least one community-based organization as a Navigator** serving those who seek health insurance through the Exchange — in each region of the state or statewide.
 - **Require Navigators to demonstrate competence** in providing information about Qualified Health Plans offered through the Exchange, Medicaid and other public programs, as well as the private insurance market in the state.
 - **Outline strict conflict-of-interest standards for Navigators**, restricting anyone from that role who receives financial compensation from an insurer for enrolling people in certain health plans in or outside the Exchange.
 - **Clarify the linguistic and cultural competency requirements for Navigators**, drawing on the expertise of outreach workers and benefits assistance providers who currently facilitate applications for Medicaid, SSI/SSDI, and other public programs. Navigators should be representative of the cultural and linguistic composition of the community or service area.
- 3. Enrollment and Eligibility:** It is critical to minimize barriers to enrollment in health plans offered through the Exchange and in public insurance plans by means of aggressive outreach and education, employing call centers outside normal business hours, and requiring regular consultation with stakeholders including advocates of hard-to-reach populations, as specified in sections 155.205(d), 155.205(e), 155.210(d), 155.130, and the Overview, p. 39.

LWVTN & LWVUS believe the regulations could better protect consumer interests in the following ways:

- **Require states to provide multi-lingual and culturally competent consumer enrollment assistance:** through in-person support, staffed telephone hotlines, and contracts with community groups to increase enrollment. It is especially important to provide application and enrollment assistance to people with physical or mental impairments or limited English proficiency, and to hard-to-reach populations including those experiencing homelessness.
 - **Require states to take all necessary steps to minimize wrongful denials of eligibility** for public plans and subsidized Exchange plans.
4. **Seamless Interface between Medicaid and Exchanges:** We strongly support efforts to develop a single, streamlined application for enrollment in Medicaid, CHIP, Basic Health Plans, and Qualified Health Plans offered through the Exchanges, as well as premium and cost-sharing tax credits. We agree that it is important to require Qualified Health Plans to have provider networks with a sufficient number of essential community providers serving predominantly low-income, medically underserved individuals — as discussed in section 156.235 and the Overview, pp.126–128. The sufficiency of essential community providers is important not only to individual health plans, but also to Small Business Health Option Programs (SHOP) Exchanges and Medicare markets.

LWVTN & LWVUS believe the regulations could better protect consumer interests in the following ways:

- **Require states to develop systems that make it easy for people to keep their health coverage when they move between Exchange plans and Medicaid,** which will occur for individuals with fluctuating income that triggers changes in their Medicaid eligibility.
- **Clarify what constitutes a sufficient number of essential community providers** in a manner that is broad enough to ensure adequate access to care while allowing Exchanges to engage in selective contracting to promote high-quality, cost-effective care. Measures of sufficiency should include the capacity of providers to see health plan enrollees within a designated period of time (e.g., patients should be able to see a primary care provider within 3 weeks and a specialist within 6 weeks).
- **Require every Qualified Health Plan (QHP) issuer to contract with at least one direct primary care medical home meeting HHS criteria, in every county where the QHP is operative.** Ensure that every medical home has an accessible, qualified hospital or surgery center to which patients requiring secondary or tertiary care can be referred and served in a timely manner.
- **Require every QHP issuer to include and maintain a robust range of specialty/ subspecialty providers** (e.g., neurologists, mental health and addiction medicine professionals, endocrinologists, oncologists, orthopaedists, pediatric specialists, habilitative/ rehabilitative therapists [physical, occupational, speech], dermatologists, ophthalmologists/optometrists, and dentists) who have the capacity to accept new patients in a timely fashion within reasonable proximity. Should networks be unable to provide such access, enrollees should be allowed to go out of network without incurring additional costs and such providers must be adequately reimbursed.
- **Ensure Network capacity and timely care by requiring Exchanges to adopt, at a minimum,** currently used standards/ regulations governing Medicaid managed care plans (42 CFR §§438.206-438.207).
- **Ensure that all entities designated as “essential community providers” with which Exchanges contract qualify for special pricing from prescription drug manufacturers** under section 340B(a)(4) of the Public Health Service Act.
- **Require states to eliminate burdensome verification processes,** such as fingerprinting, to reduce enrollment barriers for CHIP, Medicaid, and Exchange-based health plans.

- 5. Preventing Adverse Selection:** Adverse selection — in which sicker people enroll in coverage through an Exchange, leaving healthier, lower-cost enrollees in the insurance market outside the Exchange — could cause instability in and even failure of insurance Exchanges over time. Minimizing adverse selection helps to maintain affordable health plans for consumers and viable plans for insurers. Unfortunately, draft regulations on risk adjustment and reinsurance for the Exchanges issued by HHS will not fully mitigate the effects of adverse selection. Most of the rulemaking that would decrease the likelihood of adverse selection must therefore happen at the state level, as discussed in sections 156.50 and 156.255(b).

LWVTN & LWVUS believe the regulations could better protect consumer interests in the following ways:

- **Require insurers participating in Exchanges to charge the same premium rate inside and outside the Exchanges.**
 - **Require states to ensure that coverage is equal inside and outside the Exchanges by 1) Assessing Exchange fees on insurers inside and outside the Exchange; 2) Understanding the size of the potential market (e.g., state high risk pool, state employee health insurance pool, etc.); 3) Offering the same plans inside and outside the Exchange; and 4) Initiating disincentives for small businesses to self-insure.**
- 6. Federally Facilitated Exchanges:** According to HHS, states have several options in implementing Exchanges that can accommodate varying levels of state activity (Letter from the Secretary of HHS to State Officials, 8/12/2011):

State-operated Exchange. Under this option, the state operates all of the functions of the Exchange. HHS will certify state Exchanges by January 1, 2013. However, states can seek conditional approval if they expect to be ready in 2013. States may also choose to establish a state-operated Exchange in future years.

State Partnership Model. The Exchange could be run in partnership between the state and HHS, with some activities performed by the state and others by HHS. States and HHS can explore using a Partnership model to tailor the Exchange to local needs and market conditions. States can also use this model to transition to running their Exchange independently. We look forward to working with the states to further define this option.

Federally-facilitated Exchange. Under this option, HHS will ensure that there is a functioning Exchange in the state. HHS will work with the state to ensure coordination with the state's ongoing role in managing the private insurance market, Medicaid, and CHIP.

We consider the Federally-facilitated Exchange to be essential for states that are unwilling to carry out the exchange duties enumerated in the Affordable Care Act.

LWVTN & LWVUS believe the regulations could better protect consumer interests in the following ways:

- **Further explain the process by which HHS will determine if states will participate in a Federally-facilitated Exchange.**
- **Detail how a Federally-facilitated Exchange will operate with state programs, including Medicaid.**

Respectfully submitted,

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