



October 31, 2011

Department of Health and Human Services  
Center for Medicare and Medicaid Services  
Attention CMS-9974-P  
P.O. Box 8010  
Baltimore, MD 21244-8010  
<http://www.regulations.gov>

**Re: Proposed Rule – Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers (CMS -9974-P) – AHIP Comments**

Dear Sir or Madam:

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Center for Medicare and Medicaid (CMS) proposed rule on the Exchange Functions in the Individual Market and Exchange Standards for Employers ("the proposed rule") published August 17, 2011 in the Federal Register.

AHIP fully supports the goal evident in the proposed rule and the underlying statute to create a seamless, simplified system of coordinated eligibility and enrollment in Qualified Health Plans (QHPs) and insurance affordability programs including advanced payments of the premium tax credit, cost-sharing reductions, Medicaid, the Children's Health Insurance Program (CHIP) and any State-established Basic Health Program, if applicable. We support the proposed rule's goal of creating a process that is consumer-orientated while minimizing administrative hurdles and unnecessary paperwork.

We intend that these comments be considered in conjunction with companion comments to the two other proposed rules published on August 17, 2011 – (1) Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010 and (2) and the Health Insurance Premium Tax Credit proposed rule published by the Internal Revenue Service (IRS). Our comments reflect the input, insights, and expertise of AHIP's members who, collectively, offer comprehensive major medical insurance coverage throughout the nation. This letter addresses our primary concerns with the proposed rule, followed by a detailed comment section.

**Workability of Eligibility Determinations.** We propose revisions to several areas of the eligibility determination process to ensure a more workable process for Exchanges, health plans and consumers. We include specific comments about the verification of residency, how to enroll

October 31, 2011

Page 2



individuals without a fixed address and how to provide coverage to families that may be spread across multiple Exchanges that will result in lower administrative costs for all parties involved.

Our comments emphasize the importance of being able to communicate with enrollees about their benefits and premiums and determine the correct rating area and available QHPs. We recommend that at the point of application the Exchange require:

- A valid mailing address (e.g., post office box) and email address;
- For applicants seeking an eligibility determination for enrollment in a QHP without a fixed address, a specific location for coverage access (i.e., zip code); and
- Establishment of electronic fund transfer for payment of premiums.

Communicating this information to issuers in a timely manner will ensure a smooth enrollment process and transition to insurance coverage for the enrollee. We do not support the completion of enrollment without this critical information given the potential difficulties in locating the enrollee, providing coverage and collecting premiums.

While we understand that dependents or spouses who live outside the service area of the Exchange should have choices in where to seek coverage, we note that today health plans cover dependents or spouses who live “out of network” through the use of point of service options or agreements with other networks outside of their service area. In addition, we envision scenarios where the same QHP could be offered across multiple Exchanges. All of these approaches will be simpler to administer for the Exchange, the health plan, and the families who would need to understand how their premium subsidy could be spread across multiple Exchanges. In our detailed comments, we also discuss the importance of having a way for Exchanges to communicate with each other electronically to support these situations.

**Ensure smooth transitions between coverage programs through the use of structured eligibility determinations and redeterminations.** Our comments stress the importance of a eligibility determinations and redetermination framework that ensures an individual can select and enroll in coverage that is appropriate to their family and minimizes the administrative costs that could come from additional redeterminations during the benefit year.

We do *not* support an approach where individuals can request coverage for less than a full calendar year (Preamble at page 51206); although we agree that individuals who become eligible for a special enrollment period (SEP) may enroll later in a calendar year. To mitigate the potential for adverse selection, we recommend the use of structured annual open enrollment periods both inside and outside of the Exchange as the only time when individuals would be permitted to enroll in new coverage, except for SEPs. Allowing individuals to request and purchase short term coverage could create rating challenges for issuers and the Exchange risk adjustment mechanism and could create perverse incentives for individuals to move in and out of QHPs unnecessarily.



We recommend that Exchanges have the flexibility to implement “de minimis” thresholds for reporting changes in income. For example, one potential approach could be to limit the number of redeterminations due to income fluctuations to four annually (i.e., quarterly). This could ensure greater continuity of coverage and eliminate QHP changes late in the year (e.g., after September 30) when it would be more appropriate for the enrollee to make changes during the annual open enrollment period. In the detailed comments, we include several other recommendations to create an appropriate balance, given that the Exchange needs to account for natural consumer behavior. People will be more likely to report income decreases than increases, which could lead to challenges for individuals and families when subsidies are reconciled during their income tax filing.

**Designing an eligibility determination and redetermination process that does not increase costs for consumers and purchasers.** The eligibility determination process includes several requirements that, if implemented as designed, could lead to increased health insurance premiums. A system that does not require enrollees to pay their premiums for their medical claims to paid is financially unsound and unstable. We recommend that steps be taken to minimize the potential instances of non-payment of premiums, which have the potential to increase costs by effectively requiring premium-paying enrollees to subsidize coverage of individuals who do not.

We recognize that the ACA includes a 90-day period to afford applicants time to resolve any inconsistencies related to citizenship and immigration status. This requirement should be implemented in a way so individuals are able to obtain or maintain coverage and not be enrolled in coverage for short periods of time. While steps are taken to reduce the risk to the federal government through the reconciliation of subsidies during tax filing, there is no corresponding guidance for issuers. In our detailed comments, we recommend that:

- Prior-notification is given to QHP issuers that the enrollee’s eligibility verification is “provisional” and is subject to the 90-day period;
- Guidance is provided on how QHP issuers should proceed if the enrollee is determined ineligible for coverage and how claims payments should be addressed; and
- Different approaches for enrollment termination are established depending on whether premiums were paid in their entirety.

Regarding cases of provisional eligibility where premiums were paid and subsidies received, we recommend that termination occur on the last day of the following month assuming the issuer receives notice of ineligibility prior to the 14<sup>th</sup> day of the month. In these cases health plans should pay claims received. However, in those situations where the individual has not paid their premium, we reiterate our comments on the Exchange establishment proposed rule, health plans should be able to withhold payment on claims received on behalf of the enrollee and terminate coverage back to the date of enrollment date or last date of premium payment.

October 31, 2011

Page 4



A similar situation is created as a result of the proposal on eligibility maintenance. The proposed rule at subsection 155.330(e)(3) indicates that if individuals are determined ineligible to continue enrollment in a QHP, the Exchange will maintain eligibility for a full month following the month after the redetermination notice is sent, although it will discontinue the advance premium tax credit (APTC). This is problematic since it requires the QHP issuer to bill the member for the remaining premium balance not covered by the subsidy. QHP issuers may see increases in non-collected premiums that could have an impact on rates for all other enrollees. And, while not addressed in this rulemaking, managing the cost-sharing subsidies in these situations will also create operational challenges for QHP issuers and providers. We recommend the final regulations consider options to address these issues, recognizing the impact that unpaid premiums will have on the financial viability of health insurance exchanges.

**Eligibility of qualified employers to participate in a SHOP.** The proposed rule indicates a qualified employer may continue to participate in the SHOP if it ceases to be a small employer. The preamble at page 51223 indicates that the employer will continue to be treated as a qualified employer and may continue its participation until the employer either fails to meet the other eligibility criteria or elects to no longer participate in the SHOP. We do not support this approach due to the potential for adverse selection. We recommend that the small employer may continue to stay enrolled in SHOP coverage for a limited period of time (e.g., one year) to account for small changes in the number of employees over the state definition of what constitutes a small employer.

We appreciate the opportunity to submit these comments and remain available to discuss these and any other implementation issues at your request. If you have any technical questions about our comments, please contact Jeanette Thornton at (202) 861-1491.

Sincerely,

Handwritten signature of Dan Durham in black ink.

Dan Durham  
Executive Vice President  
Policy and Regulatory Affairs

Handwritten signature of Jeanette Thornton in black ink.

Jeanette Thornton  
Vice President  
Health IT Strategies



## **AHIP's Detailed Comments**

### **Part 155 Subpart D – Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs**

#### **Definitions and General Standards for Eligibility Determinations (§155.300)**

*Federal Poverty Level* - The proposed rule indicates that to determine eligibility for insurance subsidies the Federal Poverty Level (FPL) to be used will be the most recently published FPL as of the first day of the annual open period. This differs from the Medicaid which will use the most current FPL in effect on the first day of the current month. Since the FPL is typically released in late January, we are concerned that there would be different QHP and Medicaid FPLs in effect for most of the coverage year. It does not make sense to have conflicting rules where individuals who received a determination in the fall during the annual open enrollment period deeming them eligible for enrollment in a QHP with insurance subsidies would, upon enrollment, be found to be eligible for Medicaid based on changes to the FPL.

To address these problems, we recommend that HHS work the Internal Revenue Service and the Exchanges to ensure a smooth transition between eligibility for the premium tax credit and eligibility for government programs such as Medicaid. A way to achieve this might be to release the FPL mid-year (e.g., July), rather than in January.

#### **Eligibility Standards (§155.305)**

*Residency* – Individuals without a fixed address are eligible for enrollment in a QHP so long as they intend to reside in the state within the service area of the Exchange pursuant to section 155.305(a)(3). This raises significant operational challenges for both Exchanges and QHP issuers who will need a way to communicate with enrollees about identification cards, explanation of benefits, information about health plan wellness, disease management and other programs, the redetermination process, summary of benefits and coverage and have a way to bill the enrollee for applicable premiums if not done electronically.

Today health plans support electronic communications to those members that “opt-in” to receiving them. However, many state laws require certain health plan communications to be provided in paper format. As part of Exchange implementation, we strongly recommend allowing health plans to reduce the reliance on paper by requiring applicants to provide a valid email address - thus allowing for electronic communications with enrollees through the use of email and other secure electronic communications. Strong consideration should be given to the preemption of any state law that requires paper-based communications with enrollees so more transient individuals can communicate with the Exchange and their QHP issuer electronically.



Given that not all communication can be done electronically and that individuals are not required to have a fixed address, additional steps should be taken to ensure the QHP issuer can contact the enrollee. We recommend that the Exchange require a valid mailing address at the time of application (e.g., post office box). Individuals without a fixed address must be required to specify a location for coverage access (i.e., zip code) to determine the proper rating area and the QHPs being offered. Important lessons can be learned from state Medicaid programs that have established methods to communicate with individuals without a fixed address today. For example, Exchanges could be the required “electronic office” for those enrollees. The Exchange must also require electronic fund transfer (EFT) for payment of premiums to the QHP issuer. We recommend that enrollment in the QHP is contingent on the collection of the individual’s portion of the premium.

A system that does not require enrollees to pay their premiums for their medical claims to paid and does not provide QHP issuers with the information they need to administer health insurance coverage on their behalf could become financially unsound and unstable as a result of unnecessary coverage transitions. Affording the QHP issuer access to an email address, mailing address and premium payments collected by EFT will ensure a smooth enrollment process and transition to insurance coverage for the enrollee.

***Partial benefit year coverage*** – The preamble indicates that the residency requirements for QHP eligibility do not require an individual to reside in the Exchange service area for the entire benefit year –thus individuals can request coverage for less than a full calendar year (Preamble at page 51206). We recognize that we live in a mobile society, and that people may move into new service areas. If this is meant to propose shorter duration policies, however, we would oppose this recommendation. Allowing coverage that is not effective for an entire year could incentivize individuals to move in and out of QHPs unnecessarily. To mitigate the potential for adverse selection, we recommend the use of structured annual and special open enrollment periods both inside and outside of the Exchange as the only time when individuals would be permitted to enroll in new coverage. We note that the experience seen in states with child-only coverage demonstrates the need for structured enrollment periods to address adverse selection.

We do *not* support an approach where individuals can request coverage for less than a full calendar year; although we agree that individuals who become eligible for a SEP may enroll later in a calendar year. Allowing short term insurance coverage creates several operational challenges related to rating, pricing and continuity of insurance coverage and does not lend itself to long-term and stable health insurance coverage envisioned by the ACA. Typically short term policies are priced differently than full-year policies to account for differences in healthcare utilization. Effective and timely communication would be critical. At enrollment the Exchange would need to provide the QHP issuer with a set termination date for coverage. In the cases where the individual enrolled in coverage elsewhere (either through the originating Exchange or a new Exchange), a technical mechanism would need to be established for Exchanges to communicate with each other to ensure alignment in effective and termination dates.



***Special rule for family members living outside the service area of the Exchange of the primary tax payer*** (§155.305 (a)(3)(iv)) – In the proposed rule, dependents or spouses who live outside the service area of the Exchange have a choice: to seek coverage from either the Exchange of the primary tax payer, or the Exchange where the spouse or dependent resides or intends to reside. Today health plans cover dependents or spouses who live “out of network” through the use of point of service options or agreements with other networks outside of their service area. In addition, we envision scenarios where the same QHP could be offered across multiple Exchanges. All of these approaches will be simpler to administer for the Exchange, the health plan, and the family who would need to understand how their premium subsidy could be spread across multiple Exchanges.

For families that are enrolled in coverage across multiple Exchanges, we recommend that HHS through the proposed “federal data hub” or other means establish an electronic mechanism for Exchanges to communicate with each other. Exchanges will need to verify the existence of coverage provided through a separate Exchange and to verify if the primary tax payer has access to employer-sponsored coverage. The addition of this hub functionality would also simplify reporting for the family in not having to provide the same information to multiple sources and reduce reporting challenges for QHP issuers who would not generally have access to this information.

### **Eligibility Verification for Enrollment in QHP (§155.315)**

***Enrollment while Inconsistencies are Being Resolved*** - The proposed rule, at subsection 155.315(e) permits enrollment in a QHP, to the extent the applicant is otherwise qualified, while inconsistencies are being resolved related to citizenship and immigration status. During such time, the Exchange must ensure that advance payment of the premium tax credit (APTC) and cost sharing subsidies are provided, so long as the primary taxpayer attests that he/she understands that any subsidies received are subject to reconciliation.

The creation of a framework that will lead to applicants being enrolled in coverage for a short period of time poses several major operational challenges and creates inefficiencies. While we recognize that the 90-day period was included in the ACA, depending on the effective date of coverage for the QHP (i.e., whether this eligibility is being determined for a SEP or part of the annual open enrollment period) it will create unnecessary transitions out of coverage (i.e., “churn”) in the system; raising the operating cost of the Exchange. It could also limit the potential benefits for enrollees of health plan quality improvement programs and could create challenges to the implementation of the risk adjustment mechanism. Provisional enrollment also could create a situation where enrollees do not pay their full premium given the ninety day grace period prior to termination for the non-payment. As currently proposed during this period their medical claims will continue to be reimbursed.



We recommend the final regulations set rules for how a health plan should terminate enrollment and handle any claims payments that were paid during the 90-day period. Implementation of our recommendations would require Exchanges to notify issuers that the enrollee's eligibility verification is "provisional" and is subject to the 90-day period. The rules should include different approaches depending on whether premiums were paid in their entirety:

- All premiums were paid and subsidies received – enrollment ends on last day of the following month assuming the issuer receives notice of ineligibility prior to the 14<sup>th</sup> day of the month. In these cases health plans should pay claims received.
- Premiums are not paid in full – for these situations, we reiterate our comments on the Exchange establishment proposed rule. We recommend that health plans should be able to withhold payment on claims received on behalf of the enrollee and terminate coverage back to the date of enrollment date or last date of premium payment.

***Verification of Residency*** – We are concerned that the verification of residency proposed in section 155.315(c) will only be conducted via attestation without further documentation required. This is problematic given that residency location is needed to determine the available QHPs and applicable geographic rating area. Within an Exchange service area there will be different health plan rating areas to account for geographic differences in medical costs. We recommend that Exchanges are permitted to verify residency through other available data sources.

### **Eligibility Redetermination during a Benefit Year (§155.330)**

To ensure that the individual's eligibility reflects his or her circumstances, the proposed rule would require individuals to report eligibility changes within 30 days including changes in incarceration status, residency, immigration status, household income, household size, or the availability of qualifying coverage in an eligible employer-sponsored plan. The responsibility to report these changes should belong to the enrollee who will best understand their specific circumstances and thus, we do not support the Exchange conducting proactive redeterminations based on available data during the benefit year. We also support the 30-day notice requirement, and believe it provides adequate time for the individual to provide information.

The proposed rule requests comments on whether Exchanges should be permitted to limit the types of changes that are required to be reported (i.e., only report income changes of a certain magnitude). It is important that there is a balance between ensuring individuals have selected and enrolled in coverage appropriate for their family, while minimizing administrative costs associated with redeterminations during the benefit year. We support an approach where Exchanges have the flexibility to implement "de minimis" thresholds for reporting regarding income.



We recommend that the Exchange focus its efforts on those individuals who are on the cusp of a particular subsidy level or eligibility for cost-sharing subsidy. In these cases a small income change could lend itself to major eligibility changes. One approach would be to limit the potential number of redeterminations due to income fluctuations to a quarterly basis. This could ensure greater continuity of coverage, preventing QHP changes late in the year (e.g., after September 30) when it would be more appropriate for the enrollee to make changes during the annual open enrollment period. The Exchange will also have to account for natural consumer behavior. People will be more likely to report income decreases than increases, which could lead to challenges when subsidies are reconciled during income tax filing. The ramifications of not reporting income changes need to be clearly presented to consumers upfront.

Given the enrollee is responsible for reporting changes, we recommend that Exchange websites include tools and calculators that help individuals determine under what circumstances to report information, and whom to contact. The calculator required under section 155.205(d) of the proposed rule should have features that apply to the redetermination process including calculations of the impact of income changes on subsidy levels (i.e., APTC and cost-sharing). In addition to being available via the Exchange website, we also recommend Exchanges make the tools available for QHP issuers to use on their websites and for health plan customer service staff.

We note that health plans may often be the first to become aware of changes in an individual's circumstances that would necessitate the need for a new eligibility redetermination during the benefit year. For example, a sudden nonpayment of premiums could indicate that the individual has become unemployed or suffered a significant decrease in their income. We recommend the regulations allow issuers to report potential eligibility changes directly to the Exchange.

If the reporting of eligibility changes takes place through multiple channels careful attention must be paid to data quality issues. We understand that in the Medicaid program there are constant challenges related to who is the primary source for information. When health plans have correct information like address or Social Security Number it is often overridden by state Medicaid agencies who may not have the most current information. It will be important to have standard operating procedures in place regarding the responsibilities of the QHP issuer and the Exchange to ensure the information at the Exchange is up to date and whose data will be considered the "primary source of truth."

**Data Matching** – We support the proposed rule's framework for data matching where Exchanges are only required to conduct data matching as needed. Today little is known about the potential fees the federal government will charge Exchanges to access the federal data services hub to gather critical information from the Social Security Administration, the Department of Homeland Security and the Department of the Treasury. We understand these fees will most likely be passed on to QHP issuers as part of the assessments. We would like to emphasize our comments on the Exchange establishment proposed rule here – we recommend that any



Exchange assessments on health insurers be treated as a state regulatory assessment, and considered outside the MLR calculation, consistent with the provisions of §2718(a) of the Public Health Service Act.

***Eligibility Maintenance (155.330(e)(3))*** – The proposed rule indicates that if individuals are determined ineligible to continue enrollment, the Exchange will maintain eligibility for a full month following the month after the redetermination notice is sent, although it will discontinue advance payments of the premium tax credit. An individual could also terminate on their own per section 155.430 of the Exchange establishment proposed rule.

We are concerned about the proposal to maintain an individual's eligibility for a full month following the month after the redetermination notice is sent. This approach will require the health plan to bill the member for the remaining premium balance not covered by the subsidy. While we support consumers having the option to continue coverage without the subsidy, as a practical matter it may be difficult to collect these additional premiums, which could trigger the grace period in section 155.430, leaving health plans accountable for claims received during this period and the amount of the premium provided via subsidies. QHP issuers may see increases in non-collected premiums that will have an impact on rates for all other enrollees.

A system that does not require enrollees to pay their premiums for their medical claims to paid is not sustainable. We recommend the final rule consider options to address these issues, recognizing the impact that unpaid premiums will have financial viability of health insurance Exchanges. Increased premiums will make individuals less likely to purchase coverage through Exchanges thereby leading to a reduction in the number of health insurers that choose to participate. And, while not addressed in this proposed rule, managing the cost-sharing subsidies in these situations will also create operational challenges for QHP issuers and providers.

A more stable and sustainable approach would be to ensure the enrollee is transitioned to new coverage as soon as possible, avoiding the need to continue enrollment for the additional month. If this is not possible, we recommend that the redetermination notice clearly advise the enrollee that their coverage will terminate at the end of that additional month and they will be liable for the portion of the premium previously covered through the subsidy. Enrollees need to be advised of their options – either they can return to the Exchange for a redetermination to change their QHP selection or continue enrollment and fund the entire cost of the premium given the APTC will end in that current month.

### **Annual Redetermination Notice (§155.335)**

The establishment of a structured annual redetermination process that is established at the federal level is a critical element of providing access to affordable health coverage in the individual market, given the presence of a very weak enforcement mechanism for the individual mandate.



Strategies that encourage the maintenance of health insurance coverage will help mitigate the potential for risk selection in the market, whether inside or outside of the Exchange.

We support consistency in the processes for annual and benefit year redeterminations that are established at the federal level. With regard to the timing of the annual redetermination notices, we recommend they are distributed just prior to the start of the annual enrollment period to negate unnecessary switches throughout the year. Only individuals that want to affirmatively change their QHP should have to take action during the annual enrollment period. All other individuals should continue to be enrolled in their existing coverage.

#### **Administration of Advance Payments and Cost-Sharing Reductions (§155.340)**

The proposed rule requires Exchanges to notify an enrollee's QHP issuer if it determines that his eligibility has changed. We recommend a specific timeliness standard for this notification is established. It will be critical for health plans to receive timely communications from state Medicaid, CHIP and Basic Health Programs regarding eligibility determinations about existing QHP enrollees.

#### **Coordination with Medicaid, CHIP, BHP and the Pre-existing Condition Insurance Program (§155.345)**

Regarding the requirement that Exchanges must conduct a basic eligibility screening for individuals potentially eligible for Medicaid based on other factors including disability, it is critical that the costs of these screenings is born by the state Medicaid agencies, not the Exchange.

If the applicant is otherwise eligible for insurance subsidies, the Exchange must provide the applicant with APTCs or cost-sharing reduction until the other program notifies the Exchange that the applicant is eligible for such program. This proposal creates operational challenges for health plans, given that Medicaid coverage is retroactive, because the health plan will have to address claims paid during that timeframe.

#### **State Flexibility Regarding Data Sources**

We support the option of providing state flexibility in data sources, so long as they reduce the administrative costs and burdens on individuals, while maintaining accuracy and minimizing delay (see for example, 155.315(f), 155.340(e)). Information about which states take advantage of this option should be made available to the public and transparent to applicants during the eligibility verification process.



**Part 157 Subpart C – Standards for Qualified Employers**

**Eligibility of Qualified Employers to Participate in a SHOP (§157.200)**

The proposed rule indicates a qualified employer may continue to participate in the SHOP if it ceases to be a small employer. The preamble at page 51223 indicates that the employer will continue to be treated as a qualified employer and may continue its participation until the employer either fails to meet the other eligibility criteria or elects to no longer participate in the SHOP. We do not support this approach due to the potential for adverse selection. We recommend that the small employer may continue to stay enrolled in SHOP coverage for a limited period of time (e.g., one year) to account for small changes in the number of employees over the state definition of what constitutes a small employer.