



October 31, 2011

The Honorable Donald M. Berwick
Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-9974-P: Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers

Dear Administrator Berwick:

Medicaid Health Plans of America (MHPA) is pleased to offer comments to the Proposed Rule on Exchange Eligibility in the Affordable Care Act (76 Federal Register 51202, August 17, 2011).

MHPA is the leading trade association solely focused on representing Medicaid health plans. Its members' 90 managed care plans serve more than 14 million Medicaid beneficiaries in 33 states and the District of Columbia. MHPA represents both non-profit and for-profit plans, ranging from large multi-state insurance corporations to small community-based plans.

Medicaid health plans have a strong interest in potentially participating in state exchanges, and are interested in assisting you in creating a regulatory environment that both encourages their participation if they meet the requirements of other Qualified Health Plans, but does not require it. Medicaid health plans are well-suited to cover the exchange population, many of whom are lower-income, because they have experience and expertise in contracting with safety-net providers to meet the unique needs of this population.

While there are many aspects of the Proposed Rule our members have an interest in ensuring are workable, we will confine our comments to a set of issues our members have identified as priorities.

§155.305 Eligibility standards.

The preamble of the Proposed Rule at §155.305(a)(1) allows an individual to seek coverage for less than an entire benefit year, and appears to be referencing those who may be planning to

enter or leave the country or move between service areas for employment purposes at some point during a benefit year. We urge HHS to clarify that this is not intended to require QHPs to issue policies of duration of less than one year to the general population. Short duration insurance coverage would result in adverse selection as individuals move in and out of QHPs more frequently, and would create operational issues related to rating, pricing and continuity of coverage and care management. Policies of duration of less than one year should only be issued when there is a triggering event such as a change in citizenship, residency, or program eligibility based on a change in income.

The Proposed Rule at §155.305(a)(3)(iv) allows dependents and spouses living outside of the service area of the Exchange of the primary taxpayer to request coverage in the Exchange that serves the area in which they reside or expect to reside, or in the exchange that serves the area in which the primary taxpayer resides. MHPA believes the Department of Health and Human Services(HHS) should not require that QHPs meet network adequacy requirements for dependents living outside the service area or otherwise be required to apply in-network cost sharing and benefits to out-of-network services and providers. Costs would be increased significantly if in-network adequacy requirements were necessary for dependents living outside of the service area. However, QHPs that currently have established networks that could serve out-of-area dependents should be allowed to provide in-network services out of the service area, and their premiums should be permitted to reflect the additional costs associated with such a benefit. In addition, we urge HHS to permit QHP issuers to determine premiums for family coverage by family member, and as such rates for dependents who reside out-of-state should be permitted to vary based on the geographic area in which the dependent resides to accurately reflect the costs of caring for that dependent in their service area of residence. HHS should also allow such QHPs to include out-of-area network information on exchange websites to allow exchange enrollees who need network coverage outside of their immediate area to adequately assess the QHP options available.

§155.330 Eligibility redetermination during a benefit year.

MHPA supports the concept of continuous coverage, smooth transitions between coverage, and preventing gaps in coverage. At 155.345(b)(2), the Proposed Rule requires the continuation of

advanced payments of the premium tax credit and cost-sharing reductions during a pending determination of Medicaid or CHIP eligibility, without repayment of the advanced payments if the individual is found to be eligible for Medicaid or CHIP at an earlier date in time. MHPA believes this is an appropriate and necessary policy to ensure that both 1) individuals who are erroneously enrolled in QHPs through no fault of their own are not financially responsible, and 2) Medicaid doesn't incur claims for services through retroactive enrollment.

Additionally, MHPA urges HHS to consider a process for the correction of erroneous coverage determinations when they are identified that ensures a seamless transition from one program to the other that is effective prospectively only, and not retrospectively, so as to not hold health plans liable for claims incurred when individuals were not enrollees or attempt to recover premium tax credits from plans when the Exchange makes an error.

However, once the individual is found to be eligible for Medicaid or CHIP or other minimum essential coverage, the Proposed Rule at §155.330(e)(3) requires an Exchange to maintain eligibility for enrollment in a QHP for a full month after the month in which an enrollee is notified of being ineligible for enrollment in a QHP because of eligibility for other minimum essential coverage, including Medicaid, although the Federal Government will discontinue advanced payments of the premium tax credit and cost-sharing reductions. MHPA requests HHS either drop this one-month continuation of QHP eligibility, allow for continuation of advanced payment of the premium tax credit and cost-sharing reduction, or provide clarification on premium payment source options for the QHP for this month, whether from Medicaid, the Exchange, or the enrollee. MHPA also believes that if a QHP issuer also offers a Medicaid plan in the same service area, HHS should consider encouraging states to identify for individuals side-by-side plans that are available when their eligibility status changes and eligibility for minimum essential coverage is established.

§155.345 Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-Existing Conditions Insurance Program.

The Proposed Rule seeks comments on how best to achieve integration between the Exchange, Medicaid and CHIP. MHPA believes there should be continuous coverage in the correct programs in which individuals qualify, smooth transitions, and, to the extent possible, minimal disruption of coverage for

enrollees accustomed to receiving care from a single provider or group of providers. MHPA has two suggestions to encourage continuity of care.

While many Medicaid health plans may be interested in participating in Exchanges and well-qualified to do so, MHPA does not believe CMS or States should require Medicaid plans to participate in Exchanges as a condition of receiving Medicaid contracts. Plans targeting low-income populations eligible for public programs, such as Medicaid and CHIP, are subject to different requirements and rules than commercial plans, have different networks of providers, and may not have the back-office capabilities to offer commercial products. These plans have experience with and often specialize in low-income populations and may not be interested in offering commercial insurance to higher-income populations. Likewise, MHPA believes commercial plans should not be required to participate in Medicaid and CHIP as a condition of being QHPs. Requiring insurers that seek to offer qualified health plans to also offer Medicaid plans might discourage their participation in the State Exchanges.

Instead, CMS and States could encourage issuers to offer the full spectrum of QHPs, Medicaid, CHIP, and standard benefit plans for the Basic Health Program by identifying for individuals what side-by-side plans are available when an enrollee's eligibility status changes. This option would reduce the impact of churn and provide an incentive for plans to participate across all programs, without requiring it. It also promotes continuity of care by increasing the likelihood that existing doctor-patient relationships could be maintained.

In comments submitted earlier to HHS, MHPA has also proposed a transition period be established for a person moving between Medicaid, CHIP or Exchange coverage to allow them to continue a treatment in progress for a limited period of time, similar to Medicare Part D. We still believe these ideas deserve consideration in the Final Rule.

The Proposed Rule does not address situations where the Exchange or Medicaid makes erroneous coverage determinations. MHPA urges HHS to consider a process for the correction of erroneous coverage determinations when they are identified that ensures a seamless transition from one program to the other that is effective prospectively only, and not retrospectively, so as to not hold health plans liable for claims incurred when

individuals were not enrollees or attempt to recover premium tax credits from plans when the Exchange makes an error.

On behalf of MHPA and our member plans, we thank you for consideration of these comments.

Sincerely,

A handwritten signature in cursive script, appearing to read "Thomas L. Johnson".

Thomas L. Johnson
President & CEO