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VIA ELECTRONIC SUBMISSION

October 4, 2010

Jay Angoff, Director
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Baltimore, MD 21244-8010

Re: OCIO-9989-NC

**COMMENTS REGARDING THE EXCHANGE-RELATED
PROVISIONS OF THE AFFORDABLE CARE ACT**

Dear Mr. Angoff:

Northwest Health Law Advocates is a nonprofit consumer organization based in Washington State whose mission is to achieve a seamless and equitable health care system, in which individuals are assured of basic rights and protections, and continuity of care, regardless of who they are and the type of health insurance they have. Our work focuses on issues of concern to low- and moderate-income individuals and families.

Because the rules by which the Exchanges operate will determine the ability of the reformed system to achieve the goals we envision, we greatly appreciate the opportunity to submit comments on key questions regarding development of exchange-related provisions.

We have reviewed and enthusiastically support the comments of the following national consumer advocacy organizations: National Health Law Program, Families USA, Center on Budget and Policy Priorities, Georgetown Center for Children and Families, and National Senior Citizens Law Center. In addition, we would like to make the following supplementary points that are based on our experience assisting and representing individuals in Washington State. A few particular aspects of Washington's existing medical programs provide relevant lessons:

- The "Apple Health for Kids" program is a unified children's health program, including children who are eligible for Medicaid, CHIP, and the state-funded health program. Eligibility is determined in a unified, fairly

streamlined manner, and determinations regarding eligibility for federal matching funds are done at the “back end,” after children are placed on the program, making for a quicker and simpler application process.

- The state-funded Basic Health subsidized insurance program has features very much like the Exchanges, i.e., the state agency handles eligibility for subsidies and contracting with and selecting participating health plans. It has higher income eligibility levels and different rules from the state’s other medical assistance programs, and the programs have resided in two different agencies (although restructuring is underway). Basic Health refers children and pregnant women to the other agency for eligibility determinations in a type of “screen and enroll” process. However, the state is just beginning to address issues involving coordination and “siloes” eligibility determinations for adults transitioning between programs/agencies.
- The major publicly-subsidized programs – Medicaid and Basic Health – both rely heavily on managed care. The state has established fairly unified policies regarding health plan contracts; both programs contract with almost the same health plans. Thus, a person transitioning between Medicaid and Basic Health, or vice versa, can almost always stay with their existing providers. (Unfortunately, Basic Health is now largely closed to new enrollment due to a funding cap.)
- We have participated in and observed many years of activity of advisory committees to the Medical Assistance and Basic Health programs. It is very hard to involve consumers in a meaningful way in these forums unless they are supported and mentored to enable them to truly participate. Their perspectives add great value to the process.

We have the following comments based on this experience:

Exchange Planning: Governance

As other advocates point out, “States must be required demonstrate that consumer advocates and small businesses will be adequately represented, that meetings and decisions are transparent to the public, and that the exchange’s work is sufficiently insulated from insurance industry influence and other conflicts of interest.” We want to emphasize that it is not enough to have consumers present on the roster. They need to be supported, mentored, and compensated for their time and expenses in attending meetings to address the inherent resource inequities between them and people whose participation and preparation time is paid for by their employers.” The OCIIO should require states to have a plan for engaging a mix of consumers and consumer advocates. This plan should include funding to support their

governance-related activities, both in terms of logistics (costs of transportation, parking, child care, etc.) and paid participation in meetings and mentor sessions.

The governance of Exchanges with regard to overlap with Medicaid administration requires much consideration and may have varied approaches among the states. This is particularly true for states choosing the Basic Health Option, which must connect seamlessly to both the Exchange(s) and to the Medicaid and CHIP programs. It will be important for OCIO to create criteria along the lines discussed in the national advocates' comments, while allowing states to determine which agency would best meet the requirements. Prominent among these criteria should be the ability to interface with consumers, simplify the enrollment process, prevent gaps in coverage for people in transition, and (in a robust exchange) enforce minimum standards.

Implementation Timeframes and Considerations

Advocates have commented that the renewal of Exchange Planning and Establishment Grants (beyond the initial grants that will be provided in 2010 and early 2011) should be tied to states annually submitting documentation and meeting certain deadlines and benchmarks. We strongly agree, and would like to request that HHS also obtain some independent information - asking consumer groups and individual advocates directly about whether the state is involving them meaningfully in the process. OCIO should also ask these participants for feedback on the state's progress report. Independent evaluation is important – more than any procedural requirement, this will give stakeholders a non-trivial role in the process, encourage real dialogue, and make the state more accountable.

Exchange Operations – Uniform Standards vs. Flexibility

We support the advocates' comments regarding the need for uniform standards to ensure that consumers are fairly treated. We would like to emphasize that the single web portal is a sort of "black box;" it receives applications for a multiplicity of programs, has a system for making decisions, and out the other end comes offers of enrollment. It is very important to have uniform standards to ensure full and prompt determinations as well as premium payment accommodations that enable continuity of health insurance coverage for all those who apply. One particular issue that will need to be addressed is how these systems handle eligibility during the time period that eligibility is being reviewed. In Basic Health, there can be issues for enrollees coming from Medicaid to BH as follows: Ms. A. receives a termination notice from Medicaid on October 22, effective October 31. She contacts BH that week but is told that she needs to complete a new application, the agency needs to verify her income and address, and her premium has to be determined. Even if all her paperwork is in order on November 5, it's too late to pay a December premium (payment is due on the 5th of the month prior to enrollment and must be mailed; there is no online payment option). She pays her January premium but has no insurance in November or December. Uniform standards are needed to prevent such gaps.

Access and Availability

NoHLA supports all the points made by advocates in this area. In addition, states should be required to provide or arrange for navigators or other special assistance to self-employed consumers who are both the employer and the employee. When applying for insurance, they will be faced with sometimes complex choices regarding whether to purchase as an individual or as a small business. They must consider factors such as the impact of small business tax credits, the comparative prices of insurance products, and differences in the available products, questions that are not necessarily going to be addressed through the benefits portal but may be very important in a person's determination of how to best access health care.

Certification Criteria – Network Adequacy, Choice and Availability of Providers

Network adequacy is a critical aspect of health reform, as emphasized by other advocates. We agree that a critical piece of this is a reliable directory of participating providers. The directory must not only show who participates in the network but which providers are actually accepting new patients. In Washington's Medicaid managed care program, this has been a sore point; frequently, when a patient has contacted a provider on the list, it turns out that the provider is not accepting new patients. There must be a requirement that these lists, upon which patients rely in choosing plans, are accurate, and there must be a mechanism for penalizing plans if their lists are inaccurate.

Similarly, OCIO should establish minimum standards for plans to notify the Exchange of the loss of a material provider (Washington's Medicaid managed care contract requires 90 days' written notice), and for the plan to notify enrollees and give them time to switch to new providers (in Washington, within 15 days after the plan receives notice from the provider). There is also a requirement for plans to notify enrollees 60 days in advance of a decrease in service area.

Facilitating a Sufficient Mix of QHPs to Meet the Needs of Consumers

In addition to the comments of other advocates, we think that not only should Medicaid plans be incentivized to offer exchange coverage, but also that commercial plans in the exchanges should be incentivized to participate in Medicaid, so when their enrollees experience a drop in income or the loss of a job – perhaps due to illness – they are not forced to change health care providers.

Enrollment and Eligibility – Open Enrollment and Special Enrollment

Safeguards are needed for new applicants seeking coverage during open enrollment, to make sure the enrollment period does not lapse if the state takes too long in processing Medicaid, CHIP or Basic Health eligibility, for example, in a case where there are delays in obtaining

verification. If the state determines the person ineligible, she must be offered enrollment in the Exchange regardless of whether the open enrollment period has expired while the application was pending.

Coordination of Eligibility and Enrollment

The “no wrong door” approach of the Affordable Care Act will facilitate enrollment greatly. Whether or not the agencies determining various eligibility are co-located, the most important feature is a trackable referral process between the agencies. Our state Basic Health program sends applications including children to the Medicaid/CHIP agency which determines children’s eligibility. Robust data exchange and computer interfaces are needed to eliminate delays in this process.

To ensure seamless navigation between programs, as stated above, federal regulations should require that state Medicaid programs and/or Exchange plans have sufficient grace periods to enable gap-free transitions to a prospective premium-based program. This should not be too burdensome as most people’s premiums will be subsidized, but a system for reconciling payment should be required.

There should also be protections for subsidized Exchange enrollees who fall behind in their premiums, to enable them to re-enroll promptly upon paying their premiums, without having to serve exclusionary periods. The Washington Basic Health program has 1-year exclusionary periods that impose a hugely disproportionate penalty to people who have missed a couple of payments due to financially difficult circumstances. It’s highly doubtful that such penalties could be imposed anyway in a system that has an individual responsibility requirement and no pre-existing condition waiting period. It would be beneficial to offer income screening for re-enrollees to ensure their premium obligation is set at the correct level.

Consumer Experience – Design Features

The web portal should seamlessly connect to eligibility determination processes. Federal rules should require an application tracking system that ensures timely and accountable determinations. Individuals should get a receipt for their application that includes contact information for the agency and person processing the application, as well as expected response time and information about how to expedite the process (e.g., collecting needed verification).

Connections to other programs should also be available through the portal, as other advocates have mentioned, but in a way that does not slow down the determination of health program eligibility. This had been an issue in Washington State until the agency developed a way to handle the relatively simpler health program determination and issue a decision while the lengthier verification process for other programs was still pending. It is very important to retain the unified approach for public benefits and reconcile it with the ACA’s focus on a health-only application process.

In conclusion, we appreciate your consideration of these comments and look forward to providing additional information to OCIIO. Please let me know if I can provide additional information.

Sincerely,

Janet Varon
Executive Director
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