



A Passionate Voice for Compassionate Care

October 31, 2011

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

REF: CMS-9989-P: Patient Protection and Affordable Care Act: Establishment of Exchange and Qualified Health Plans

Dear Dr. Berwick:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of the Catholic health ministry representing more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities, and related organizations, I am pleased to provide comments on the referenced notice of proposed rulemaking (NPRM) on the establishment of Exchange and qualified health plans (QHPs) under the Patient Protection and Affordable Care Act (ACA).

CHA supports establishing health insurance Exchanges that enable individuals and small businesses to more easily compare and purchase health insurance policies in a context of information transparency and consumer choice. Through these Exchanges, consumers will have access to qualified health plans that provide a comprehensive set of services while prohibiting federal funds from covering abortion. These provisions of the ACA will contribute to making health care available and accessible to everyone in a system that is patient centered and designed to address health needs at all stages of life. We welcome the proposed regulations to begin the process of implementing these provisions and would like to offer the following comments.

Exchange Governance (§ 155.110(c))

If a state chooses to establish an Exchange as an independent state agency or non-profit entity established by the state, the NPRM proposes that the board of that entity may not have a majority of voting members with a conflict of interest, such as individuals or

entities that sell insurance. We agree that conflicts of interest must be avoided to protect consumers, and suggest CMS consider requiring that the board be free of such conflicts, or allow a lower threshold than the proposed 49% of members. The expertise and knowledge of insurers, crucial to the establishment and success of an exchange, could instead be provided through an advisory committee.

CHA agrees that boards should include representatives with a range of experience and expertise in the health care field. We recommend that boards include consumers and local health care providers.

Stakeholder Consultation (§ 155.130)

CHA strongly supports the proposed requirement that Exchange consult regularly and on an ongoing basis with a broad range of stakeholders. The Exchange needs to consult with the full range of health care providers (including hospitals, skilled nursing facilities, home health agencies, and other providers) meeting different service needs as well as different service areas (urban, rural) if the Exchange is to understand and fulfill the breadth of its responsibilities related to access to care for individuals and small businesses seeking insurance. The consultation should occur throughout the development, establishment, implementation and ongoing operations of the Exchange.

Financial Support for Continued Operations (§ 155.160)

The ACA requires states to ensure that Exchanges are financially self-sustaining by January 1, 2015, after which time federal funds will no longer be available for Exchange operations. After that time, the proposed regulation provides that states may fund Exchange operations through assessments or user fees on participating issuers, or may use funds generated in other ways. In the Preamble to the NPRM, CMS suggests states may use broad-based funding sources, such as general state revenues, provider taxes or other funding. CHA is supportive of the idea of broad-based state financing. However, we oppose allowing the use of a provider tax to finance the operation of the Exchange. The Exchange is a distribution system for insurers, who are expected to be able to lower their administrative and marketing costs as a result of the Exchange operations, and there is no rationale for a targeted fee on providers, some of whom may not even be included in every network of the plans in the Exchange.

Consumer Assistance Tools and Programs (§ 155.205)

Consumer assistance is the heart of the Exchange. People looking for insurance must be able to find, contact and use the Exchange with ease, and the Exchange must provide information that consumers can understand and use effectively to make their decisions about what health plan will best suit their financial and medical needs. CHA strongly supports CMS' proposal that Exchange must include call centers, Internet Web sites, an

exchange calculator, consumer assistance (in addition to the Navigator program) and outreach and education. In addition to the provisions as proposed, CHA recommends the following:

Staffed call centers should be operated outside of regular business hours to accommodate the many workers who cannot conduct personal business while at work. Call centers should also be accessible by limited English proficient callers and by callers with hearing disabilities.

We agree Exchange Internet Web sites must be accessible by people with disabilities and people with limited English proficiency. Web sites should be designed incorporating or compatible with technologies used by people with disabilities to access the Internet. If there is a predominant non-English language in the state or Exchange coverage area, the Exchange should provide information in that language. In addition, all Exchange should include “tag lines” in multiple languages with information on how to find translated materials or to reach interpreters for assistance. The Web site and the Exchange Calculator potential enrollees must have the tools to easily compare information on plans’ provider networks, in- and out-of network cost sharing requirements, and access to emergency care.

Consumer assistance and outreach and education should be designed and conducted in a culturally and linguistically appropriate manner, accessible to people with disabilities, limited English proficiency individuals, and people of diverse racial and ethnic backgrounds. Activities should target groups such as the uninsured, hard to reach populations, and populations that experience health disparities.

Navigators (§ 155.210)

Exchange should seek to engage Navigators from a broad cross section of stakeholders in the community that can meet the proposed program standards. For example, many Catholic and other community hospitals have developed capacities that are very closely aligned with those identified for Navigators and should be eligible to participate so long as they meet all the standards. A great deal of community expertise has been built up over many years, often because of activities in collaboration with the State to help individuals navigate through the Medicaid program. Many hospitals already have, or can easily develop through their role in the community, relationships with employers, employees, consumers including the uninsured and self-employed individuals, and have experience performing the kind of duties the proposal sets out for Navigators. Exchanges should take advantage of the skills and relationships that already exist in the community.

Single Application (§ 155.405)

CHA strongly supports the use of one application to determine eligibility and collect enrollment information for QHPs, advance payment of the premium tax credit, cost

sharing deductions and Medicaid and the Children's Health Insurance Program (CHIP). This will make it much easier for people seeking insurance to find the right program for them, especially those who may be unaware of their eligibility for Medicaid or CHIP. We agree with having both paper-based and web-based applications. The paper application should include information on how to access the web site or other forms of consumer assistance. We also suggest the applications be available in multiple languages. The applications should only solicit information relevant to eligibility and enrollment. CMS proposes that Exchange accept applications from not only the applicant but also authorized representatives (which CMS envisions states defining) of applicants as well as someone acting responsibility for the applicant. CHA supports allowing applicants to be able to receive assistance in completing their applications, including have someone else submit it on their behalf. CHA suggests that CMS clarify that this section is not meant to limit the kinds of individuals or entities applicant may turn to for assistance in filling out the application to prior to submitting it themselves.

Initial and Annual Enrollment Periods (§ 155.410)

In the Preamble, CMS seeks comments on whether to require Exchanges to automatically enroll individuals who received advance payments of premium tax credits if their QHP is discontinued and the individual does not elect a new plan. CHA believes this would contribute to the continuity of care for individuals receiving premium assistance and supports the proposal. CHA also supports the idea of automatically enrolling in new QHPs individuals whose original QHPs are no longer available following mergers between issuers or because they have been discontinued by the issues, to avoid disruptions or delays in access to care.

While we support these proposals, Exchange should be required to make every effort to avoid these situations by providing adequate advance notice to individuals whose plans are about to be discontinued for some reason and to assist them in selecting a new QHP in advance of the end date for the old plan. Exchanges should allow anyone who has been auto enrolled a period of time in which to choose a different plan without penalty.

Special Enrollment Periods (§ 155.420)

CHA supports the proposal to provide special enrollment periods when individual circumstances change. In particular, the nature of the advance payment and reconciliation of the premium tax credit is such that individuals will be encouraged to report to the Exchange when their income changes during the year. As a result, the proposal to provide a special enrollment period when an individual is determined newly eligible or newly ineligible for advance payments of the tax credit or has a change of eligibility for cost sharing reductions regardless of whether they are enrolled in a QHP is particularly important. Income is often unpredictable for low-income individuals and this protection

will help minimize the difficulties that could result if an individual's eligibility for subsidies changes during the year.

We also support an exception that would allow a woman who is eligible for a special enrollment period, enrolled in a catastrophic plan and who is pregnant, to change the level of her coverage. This exception would permit pregnant women in this narrow circumstance to select more appropriate coverage.

Exchange Network Adequacy Standards (§ 155.1050)

Accessible health care means being able to get needed health care services in a timely manner. CHA agrees that health plan networks should include sufficient choice of providers to meet the needs of enrollees. We acknowledge, as does CMS, that exactly what constitutes sufficiency may vary according to local conditions and patterns of care. However, we suggest CMS provide more guidance to states on how to assess sufficiency. We agree that the four specific areas mentioned by CMS in the preamble, based on the National Association of Insurance Commissioners (NAIC) "Managed Care Plan Network Adequacy Model Act" provide an appropriate standard that can be adapted in the context of local conditions. Exchanges should develop network adequacy standards that will ensure:

- sufficient numbers and types of providers to assure that covered benefits are available without unreasonable delay;
- reasonable proximity of providers to the residence or workplace of enrollees, including proximity and availability of providers accepting new patients;
- a process to allow enrollees to access covered benefits through out-of-network providers at no additional cost if a network provider is not accessible in a timely manner; and
- an ongoing monitoring process of network adequacy and access to care.

Essential Community Providers (ECP) (§ 156.235)

CHA supports the proposal to require QHPs to include in their networks a sufficient number of community providers serving low-income, medically underserved populations. When determining sufficiency, an Exchange should consider whether the plan includes enough ECPs to ensure that low-income, medically underserved individuals in its service area will have timely access to the care they need.

We also support codification in the regulations of the statutory provision that the requirement to include essential community providers in qualified health plans is not to be construed to require any health plan to provide coverage for any specific medical procedure.

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Segregation of Funds for Abortion Services (§ 156.280)

CHA strongly supports the inclusion in the final regulation of the requirements of Section 1303 of the ACA concerning QHPs and abortion services. It has long been and continues to be federal policy to prohibit the use of federal funding to pay for abortion services and to protect the conscience rights of individual and institutional health care providers that choose not to perform abortion services. The provisions of Section 1303 of the ACA achieve that end.

The requirements that QHPs must not use premium tax credits or cost-sharing reduction funds for abortion services for which public funding is not allowed; that any QHP which covers abortion must collect from each enrollee two separate payments, one payment for the abortion coverage and a separate payment for the rest of the coverage; and that these separate payments be maintained in separate accounts, with any payment for abortion services made only from the abortion coverage payments account, are essential elements of the ACA. CMS and the Exchanges must ensure that these provisions are implemented and operated in full integrity with the statutory requirements.

Equally important are the statutory requirements that QHPs may not be required to provide coverage of abortion services, and that QHPs may not discriminate against any provider or facility that does not provide, pay for, provide coverage of or refer for abortions. CMS should make clear these protections apply equally to direct and indirect attempts to undermine them.

Thank you for the opportunity to comment on the proposed rule on Exchanges and Qualified Health Plans. We look forward to continuing to work with the Administration to ensure that the promise of the ACA – affordable, accessible health care available to all – is achieved. If you have any questions about these comments, please do not hesitate to contact me or Kathy Curran, Senior Director, Public Policy, at 202-721-6300.

Sincerely,

A handwritten signature in black ink that reads "Michael Rodgers". The signature is written in a cursive, flowing style.

Michael Rodgers
Senior Vice President
Public Policy and Advocacy