

## **Letter to Issuers on Federally-facilitated and State Partnership Exchanges<sup>i</sup>**

Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services

March 1, 2013

On March 1, 2013, the Center for Consumer Information and Insurance Oversight released a letter to health insurers regarding certification, approval guidelines and other aspects related to the federally-facilitated health insurance exchange and the state Partnership exchanges. The federal government will operate health insurance exchanges (AKA marketplaces) in 26 states, while 17 states and the District of Columbia will be operating their own exchanges. Seven states will formerly partner with the federal government to operate their exchange.

The letter largely builds off of the regulations outlined in previous regulatory guidance on state-based health insurance exchanges. However, it remains unclear how stakeholders, such as medical societies and other provider organizations, will provide input to the federal government in absence of a governance board-style entity required of state-based exchanges. CMS has stated that they intend to work with states to preserve traditional state insurance department responsibilities and will “seek to harmonize Exchange policy with existing state programs and laws wherever possible,” such as state licensure and solvency requirements. Consumer assistance personnel will also be trained on their state’s insurance laws and Medicaid/CHIP eligibility standards, among other relevant issues.<sup>ii</sup>

The federally-facilitated exchange will be funded by insurer user fees.

<b>Chapter 1: Certification Standards for Qualified Health Plans</b>	<b>ACP Policy</b>
<p><i>Section 1: Network Adequacy and Inclusion of Essential Community Providers</i></p> <p>In 2014, CMS will rely on state analyses and recommendation when the state has the authority and the means to assure issuer network adequacy; CMS will rely on state process based on whether state assesses network adequacy in a sufficient manner and uses standards at least as stringent as those identified in 156.230(a)</p> <p>In states without sufficient network adequacy review, CMS will accept issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity. Unaccredited issuers will be required to submit an access plan as part of QHP application (access plan based on NAIC Managed Care Plan Network Adequacy Model Act). CMS will monitor adequacy via complaint tracking or gathered network data from a QHP provider at any time to determine meeting of</p>	<p>At a minimum, QHPs should be required to meet the standards outlined in the proposed rule based on the NAIC Managed Care Plan Network Adequacy Model Act, specifically, QHP's must maintain “sufficient numbers and types of providers to assure that services are accessible without reasonable delay; arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients; an ongoing monitoring process to ensure sufficiency of the network for enrollees; and a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner.” (<b>ACP comment letter regarding health insurance exchanges and QHPs, 10/24/11</b>)</p>

<p>standards.</p> <p>The letter also outlines extensive guidelines for requiring adequate access to essential community providers, including federally qualified health centers; Ryan White providers; family planning providers; and others that serve low-income, medically underserved individuals.</p>	<p>The federal government should develop new and innovative strategies to support safety-net health care facilities, such as community health centers, federally qualified health centers, public health agencies, and hospitals that provide a disproportionate share of care for patients who are uninsured, covered by Medicaid, or indigent. The federal government should also continue to help offset the costs of uncompensated care provided by these facilities and continue to support the provision of emergency services. All patients should have access to appropriate outpatient care, inpatient care, and emergency services, and the primary care workforce should be strengthened to meet the nation's health care needs. (<b>National Immigration Policy and Access to Care</b>)</p> <p>During a transitional period, require managed care organizations to contract with essential community providers (for example, those who serve low-income populations, such as community health centers) if the managed care organizations are serving persons in underserved locations and are financed in whole or in part with federal funds.</p>
<p><i>Section 3: Rate Review.</i></p> <p>Exchanges required to consider all rate increases when certifying plans as QHPs. The letter explains the process for considering rate increases for the FFE. If a state is already conducting rate review, CMS will not duplicate such activity for the FFE, but will collaborate with states to ensure rates are reasonable. CMS will conduct outlier tests to identify rates that deviate significantly from the norm.</p>	<p>ACP supports oversight of premiums and cost increases.</p>

<p><i>Section 4: Benefit Design Review.</i></p>	
<p><i>Non-discrimination</i></p> <p>To ensure non-discrimination in benefit design, CMS will perform an outlier analysis on QHP cost sharing as part of QHP certification reviews. Outliers will be compared with QHPs with similar cost-sharing structured.</p>	<p>To provide the broadest possible choice of health plans, purchasing pools should offer all qualified health plans. If that is not done, the authority of purchasing groups to negotiate price should be limited. As an alternative, states should set a minimum threshold for the number of competing plans that must be offered, in the aggregate and by type of plan. (<b>Voluntary Purchasing Pools</b>)</p>
<p>CMS may also request insurers to modify benefit designs to eliminate discriminatory design. Plan information documents will also be reviewed to eliminate language that may discriminate against patients/enrollees.</p>	<p><i>Staff comment:</i> Reflects ACP policy. CMS has expressed that any insurer meeting the QHP certification guidelines and other requirements will be permitted to offer plans in the FFE/SPE. However, plans offered to consumers must be meaningfully different, minimizing the potential for plans that are less innovative.</p>
<p><i>Informed Consumer Choice</i></p> <p>CMS has previously stated its intention to certify as a QHP any plan that meets all certification standards. CMS believes that this approach has important benefits, including increased consumer choice and competition. To ensure that QHPs are meaningfully different and provide adequate choice of offerings, CMS will review metal levels (actuarial value), service areas covered provider networks, premiums, etc., and whether a plan's offerings are distinguishable from others. If deemed not substantially different, CMS will flag plans and insurers may amend or withdrawal its plan. A plan may justify its uniqueness by, for instance, reporting that it is based on an ACO model.</p>	<p>ACP supports counting out-of-network cost-sharing towards annual deductible and cost-sharing limitations, particularly if the enrollee does not have access to a necessary provider in their network. The rule does not reflect this policy, although CMS has indicated that preventive care rated A or B by USPSTF and immunizations provided by an out-of network provider will not be subject to cost-sharing if an in-network provider is not available.</p>
<p><i>Annual Cost-sharing Limits</i></p> <p>Outlined in the EHB rule, plan deductibles and out-of-pocket totals are capped. Cost-sharing for out-of-network care does not count towards the annual limitation.</p>	
<p><b>Chapter 2: QHP Certification for FFE, State Partnership Exchanges.</b></p> <p>For FFE : Beginning in April, plans will submit QHP applications to HIOS, CMS issues results to insurers in June, insurers revise as necessary, CMS reviews state recommendations, in August, CMS issues final QHP Certification decisions for FFE in September. Open enrollment for FFE/State Partnership Exchange (SPE) begins in October.</p> <p>SPE process is similar, although states review</p>	<p>ACP has no relevant policy on the timeline for QHP certification.</p>

<p>applications.</p> <p>QHPs will be subject to annual review and recertification process.</p> <p>Multi-state plans under contract with Office of Personnel Management will be included in QHP display with accreditation status, CAHPS data (if available), and a link to existing quality data provided by OPM.</p>	
<p><b>Chapter 3: QHP Performance and Oversight</b></p> <p>Insurer compliance plan will document how insurance plan intends to meet regulations and prevent waste, fraud and abuse.</p> <p><b>QHP Marketing:</b> QHP issuer must comply with applicable state laws re: health plan marketing. QHPs prohibited from marketing practices that may discourage enrollment of individuals with significant health needs. All plan marketing materials should contain a disclaimer noting that the plan is a QHP. Marketing materials must meet meaningful access standards for those with limited English proficiency and for individuals with disabilities.</p>	<p>The College advocates for robust oversight of QHP marketing activity to ensure that patients aren't provided false or misleading information on benefits, terms, conditions, cost-sharing requirements, provider networks, and other crucial information that would hinder their access to appropriate quality care. ACP supports efforts to prevent the use of fraudulent, deceptive and high-pressure sales tactics to enroll patients in health insurance plans, and to penalize those individuals and organizations that engage in such activities. Standards for marketing QHP health benefits plans must ensure that marketing materials must not include false or materially misleading information; and sales agents do not partake in abusive enrollment procedures such as not showing potential beneficiaries the listing of covered insurance benefits.</p>
<p><b>Chapter 5: Consumer Enrollment and Premium Payment.</b></p> <p>Outlines enrollment process for qualified individuals: completion of eligibility application for coverage/tax credits; evaluate available plans; make plan selection; redirect by exchange to insurer website to arrange for premium payment, additional processing, selection of primary care provider, etc.</p> <p>Establishes different enrollment periods: initial open enrollment, subsequent year open enrollment, special enrollment periods (relocation, birth, loss of minimum essential coverage, etc.)</p>	<p>ACP does not have relevant policy on the enrollment process.</p>
<p><i>Section 6: Grace Period for non-Payment of premiums.</i></p> <p>Issuers may terminate coverage for enrollees who</p>	<p>ACP supports legislation which requires all Payers in all health care payment systems to pay physicians' clean claims promptly within thirty days of receipt of claims. <b>(Timely Payment of</b></p>

<p>fail to pay premiums. However, enrollees who have paid their share of first month's premium in full are to be given a 3-month grace period before coverage termination for those receiving tax credits. Complete repayment of outstanding premiums will bring enrollee into good standing.</p> <p>Insurers must alert tax credit-receiving enrollees that they have entered grace period and that their coverage may be terminated at period's end.</p> <p>Insurers must also alter providers that may be affected, such as those who may treat enrollee during grace period, that an enrollee has lapsed in paying premium. The notice must state that there is a possibility that the insurer WILL NOT reimburse the enrollee during the 2<sup>nd</sup> and 3<sup>rd</sup> month of the grace period if enrollee fails to pay premium.</p> <p>Issuers should notify all potentially affected providers as soon as is practicable when an enrollee enters the grace period, since the risk and burden are greatest on the provider. Issuers should include the following information in the provider notification:</p> <ul style="list-style-type: none"> <li>• Purpose of the notice</li> <li>• A notice-unique identification number</li> <li>• The name of the QHP and affiliated issuer;</li> <li>• Names of all individuals affected under the policy and possibly under the care of this provider</li> <li>• An explanation of the three month grace period, including applicable dates, including: <ul style="list-style-type: none"> <li>O Whether the enrollee is in the second or third month of the grace period,</li> <li>O Consequences of grace period exhaustion for the enrollee and provider, and</li> <li>O Options for the provider, and</li> </ul> </li> <li>• The QHP customer service telephone number specifically for use by providers, if available.</li> </ul>	<p><b>Claims)</b></p> <p><i>Staff comment:</i> The provision on grace periods for non-payment of premiums raises significant concern. While the College does not object to the concept of granting time to enrollees to pay their premiums or cost-sharing requirements, it is concerned that the issuer does not have to reimburse providers for services provided during the grace period. This would for physicians to seek payment from their patients directly, or absorb the cost of the uncompensated care. Insurers may not have the technical capability to alert providers in a timely manner that an enrollee has entered the grace period. ACP staff has raised this concern with CMS staff and will continue to work with them to resolve this issue.</p> <p>An excerpt from the March 2013 final rule on Benefit and Payment Parameters makes a similar statement:</p> <p>The Exchange Establishment Final Rule, authorizes QHP issuers to pend or pay claims during the second and third month of a grace period in accordance with company policy and State laws. However QHP issuers must notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. We continue to believe this policy appropriately balances these financial risks, while protecting enrollees. We clarify that we expect QHP issuers to ensure throughout the grace period that cost-sharing reductions are applied at the point of collection for eligible enrollees. If an enrollee's coverage is terminated, QHP issuers may deny any claims that were pending, including the reimbursement to the provider for the value of the cost-sharing reductions. Providers could then seek payment directly from the enrollee for any services provided after the termination of coverage, including a refund for the cost-sharing reduction.</p>
<p><i>Section 10: Agents and Brokers.</i></p> <p>Agents and brokers seeking to enroll individuals through the FFE/SHOP must be licensed in state and adhere to state laws. CMS will work with licensed brokers and agents on enrollment</p>	<p>Allow participants in public purchasing pools to use and agent's or broker's services for enrollment and employee education but require commissions to be line-itemed separately from the pool premium so that consumers know the cost of extra administrative service and the cost of the plan.</p>

<p>facilitation to the extent permitted by state law. Issuers must ensure marketing actions on their behalf by agents and brokers comply with applicable federal and state law.</p>	<p><b>(Voluntary Purchasing Pools)</b></p> <p>Staff comment: Plans must abide by medical loss ratio rules which require a certain portion of premium be dedicated to medical/quality improvement expenses. Agent/Broker fees are not included as a medical expense, but fall under definition of administrative expense for plans.</p>
<p><b>Chapter 6: Consumer Support.</b></p> <p>Insurers should have their own call centers and websites for customer support. CMS will also provide customer support and is responsible for the FFE Call Center. Call Center employees will direct inquiries to appropriate state/federal agencies and assistance programs (such as Navigators) as needed. Call Center activities will include requests for general information, consumer eligibility, plan comparisons, enrollment. CMS will also operate a FFE/SPE website which will accommodate people with disabilities and will provide information in English and Spanish.</p> <p>CMS will provide funding for Navigators to serve FFE/SPE; Navigators will be expected to maintain expertise in eligibility, enrollment, and program specifications; conduct public outreach; provide information in a fair, impartial and accurate manner; facilitate selection of a QHP; make referrals to consumer assistance entities as needed; provide information in a culturally and linguistically appropriate manner that is accessible to people with disabilities.</p>	<p>ACP policy states that purchasing pool functions should include one-stop shopping for group health insurance, providing consumers with comparative information on plans, assist in enrolling individuals into plans, and offer customer service to enrollees.</p> <p><b>(Achieving Affordable Health Insurance Coverage for All Within Seven Years)</b></p>
<p><i>Section 3: Provider Directory.</i></p> <p>CMs will require QHPs to make provider directories available to the Exchange for publication online by providing web link to their network directory. CMS expects directory to include location, contact information, specialty, and medical group, and institutional affiliations for each provider. Issuers are encouraged to include such information as whether provider is accepting new patients, language spoken, provider credentials, and whether the provider is an Indian provider (Staff note: assume this means that provider would serve Native American community or Indian Health Service).</p> <p>CMS will expect QHPs to investigate and resolve consumer complaints in a timely and accurate</p>	<p>Reflects ACP policy. ACP policy states that operators should make available information about covered benefits, costs, provider networks, and quality, medical loss ratio information, plan coverage rules, and cost-sharing and any balance billing responsibility estimates. However, it does not seem that QHPs will be required to provide information on balance billing.</p>

<p>manner to ensure consumers receive the highest level of service and to meet QHP issuer participation standards. Issuers are expected to comply with all applicable state and federal laws related to consumer complaints.</p>	
<p><i>Section 6: Meaningful Access.</i> To ensure meaningful access by limited English proficient speakers and people with disabilities, QHPs are required to provide all applications, forms, and notices to enrollees in plain language and accessible and timely manner. This includes auxiliary aids and services in accordance with Americans With Disabilities Act and oral interpretation, written translations for limited-English proficient speakers.</p>	<p>The College is pleased that the proposed rule would require Exchanges to provide access to information for people with limited English proficiency as well as patients with disabilities. To ensure that patients with limited English proficiency can find a health plan that meets their cultural and linguistic needs, Exchanges should also disclose whether qualified health plans provide reimbursement to physicians and other health care professionals that reflect the cost of language services and additional time involved in providing clinical care for limited English proficiency patients. ACP policy recommends that a national clearinghouse be established to provide translated documents and patient education materials; the health insurance Exchange may fulfill this role.</p> <p><i>Staff comment:</i> This largely reflects ACP policy, although it does not indicate whether QHPs will be required to reimburse physicians for the cost of interpretation services.</p>

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<sup>i</sup> <http://cciio.cms.gov/resources/files/issuer-letter-3-1-2013.pdf>

<sup>ii</sup> <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>