Congress of the United States
House of Representatives
Washington, DC 20515

October 27, 2011

The Honorable Kathleen Sebelius
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9989-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Proposed Rule on the Establishment of Health Insurance Exchanges and Qualified Health Plans Created under the Patient Protection and Affordable Care Act (RIN 0938-AQ67)

Dear Secretary Sebelius,

We appreciate the opportunity to provide comments to the proposed rule published July 15, 2011, on the establishment of the health insurance Exchanges and qualified health plans (QHPs) that were created under the Patient Protection and Affordable Care Act. The Exchange is a critical element of the Affordable Care Act that will guarantee that consumers always have access to affordable, high quality health insurance coverage. Further, the establishment and operation of the Exchange holds the promise for achieving a fair and transparent health insurance marketplace. The Exchange also will play a pivotal role in supporting the strong consumer protections we incorporated into the Affordable Care Act.

We applaud the Department of Health and Human Services for including provisions that recognize the important role that the Exchange must play in protecting consumers. In particular, we appreciate the Department's affirmation that the federal standards are not a ceiling, but a floor, thereby ensuring a state's ability to further protect their residents. In particular, we appreciate the Department's affirmation of the law in the proposed rule that prohibits preemption of state laws that have stronger consumer protections than the federal law. We additionally support proposals requiring that all exchange applications, forms, and notices be accessible to consumers, including those with disabilities or limited English proficiency (45 CFR 155.230, 156.250, 155.230(b), and 155.120).

While we support these and other provisions, we are concerned that the proposed rule is silent on certain key issues. Additionally, we believe that several provisions should be amended in order for the Exchange to better serve and protect consumers while providing access to high quality health insurance coverage.

Recommendation 1: Ensure that there is a strong Federally-facilitated Exchange to serve consumers in states that do not establish a State Exchange.

While the new law provides states with the option to establish and have operational a State Exchange no later than January 1, 2014, section 1321(c)(1)(B)(II) of the law also requires that the Secretary of Health and Human Services establish an Exchange for consumers to access in those states where a State Exchange does not exist or is not operational by 2014. We believe strongly that the Federally-facilitated Exchange established and operated by the Secretary must be an active purchaser to obtain the best options and prices for consumers and be a leader for State Exchanges to emulate.

In her operation of the Federally-facilitated Exchange and oversight of State Exchanges, the Secretary must ensure that all Exchanges are: actively negotiating with insurers for affordable quality products; educating consumers and ensuring they have competitive and fair choices among qualified health plans; conducting rigorous rate review to ensure premium increases are not unjustifiable; and ensuring that the requirements of the Affordable Care Act are fully enforced against noncomplying plans. The statute makes clear that the Federally-facilitated Exchange must be established and operational by January 1, 2014, in accordance with the deadline for the State Exchanges to ensure consumers have access to insurance coverage if their state fails to be operational at any point on or after January 1, 2014. It is critical that consumers always have access to an Exchange to buy health insurance, regardless of where they live.

The Federally-facilitated Exchange will best succeed if it helps to make the health insurance marketplace simple and understandable for all. As such, the Federally-facilitated Exchange should be required to carry out statewide public education efforts where it is operating in order to ensure that all residents of a state are aware of its existence. The Federally-facilitated Exchange must also be available to all Americans through public assistance offices, toll free hotlines, and the internet. The Federally-facilitated Exchange must also develop understandable materials on enrollment, health plans terms and conditions, premium payments, claims payment, and dispute resolution. Finally, the Federally-facilitated Exchange should make it easy for individuals to enroll and pay premiums to available health plans.

Recommendation 2: Establish a federal standard as a baseline for the establishment of State Exchanges.

The Affordable Care Act creates a minimum level of health insurance and consumer protections for all Americans. This coverage is the basis for fulfilling new individual responsibility requirements in the tax code and helps ensure all individuals and families have access to affordable, quality healthcare. However, with regard to some insurance reforms, the proposed rules do not establish a federally defined minimum level of protection. This leaves states to create their own requirements, potentially undermining any continuity for insurers or consumers

from state to state and undermining a main purpose of legislating federal protection, namely, to ensure a nationwide minimum standard of coverage and consumer protections. We strongly recommend that the final regulation set forth a minimum federal level for all consumer protections for State and Federally-facilitated Exchanges.

One of the minimum protections that should be included is the requirement for health plans to have adequate provider networks. Consumers and insurers would benefit from developing a federal baseline for determining network adequacy based on the factors discussed in the preamble, including requirements regarding the sufficient number and types of providers necessary so that services are available without unreasonable delay and within a reasonable proximity to patients, access to out-of-network providers with no additional cost in the instance where network providers are not available, and development of an ongoing monitoring program.

Another important area is setting a federal minimum standard for fair marketing rules. Significant taxpayer dollars are going to go to private qualified health plans in the Exchange. It is imperative that we hold insurers responsible for fair marketing and outreach so patients are protected from discriminatory and fraudulent practices. Creating a level playing field with regard to marketing also helps keep costs down for insurers and in turn consumers.

Similarly, creating a process and timeline for appeals of eligibility determinations made by the Exchange would ensure that people are not disadvantaged in accessing health insurance based on where they live.

In these and other areas, it is imperative that the proposed rules establish a federal minimum level of protection.

Recommendation 3: Establish enforcement procedures for State Exchanges that fail to meet established Exchange requirements.

Section 155.106(b) of the proposed rule requires a state to notify the Department at least twelve months prior to voluntarily ceasing operation of a State Exchange after January 1, 2014. However, the proposed rule is silent on the process for enforcement or termination of a State Exchange if it fails to comply with established Exchange rules. In severe cases where such failures cannot be remedied, the Department must establish an enforcement procedure that allows the Department to operate a Federally-facilitated Exchange immediately upon the termination of any State Exchange. A delay in remedying failures or between the termination of a failed State Exchange and the establishment of the Federally-facilitated Exchange could create a gap in access to affordable, quality coverage for consumers, potentially subjecting consumers to the same problems that the Affordable Care Act is intended to eradicate.

We are equally concerned about a lack of consistency that could arise from allowing a state to go back and forth between a State Exchange and a Federally-facilitated Exchange. More specifically, section 155.106 of the proposed rule allows a state to elect to operate or, as discussed above, voluntarily cease operation of a State Exchange with a twelve month waiting period. We are concerned that state officials may use this provision to switch back and forth between a State Exchange and a Federally-facilitated Exchange, depending on political preferences and other factors. Such fluctuation will destabilize the marketplace for consumers, employers, and insurers. For example, consumers could be forced to frequently change QHPs, potentially impacting their access to providers from whom they are seeking care. QHPs could also be subject to differing requirements year to year depending on state or federal operation of the Exchange. This possibility would be particularly troubling for hard to reach and vulnerable populations, such as limited English proficient populations or racial and ethnic minorities. We urge the Department to establish parameters governing when and how this movement between a State Exchange and Federally-facilitated Exchange is allowed in order to ensure continuity in the health insurance marketplace.

Recommendation 4: The SHOP Exchange should allow as much employee choice of QHPs as possible.

The SHOP Exchange should allow for the greatest employee choice. Section 1312(a)(2) explicitly provides that employees of a qualified employer can choose the QHP that best fits their needs within the level of coverage designated by the employer through a SHOP Exchange. This provision embodies our desire to provide employees with as much choice as possible in determining the best health insurance coverage for themselves and their families. To enhance employee choice in the small group marketplace, we strongly support the proposed requirement for "premium aggregation," meaning that each SHOP Exchange provides a monthly bill to qualified employers for all amounts due to QHP issuers by the employer, collects the total amount due from each employer, and distributes the premium payments to QHP issuers. This structure ensures that employers have little to no burden from the SHOP Exchange; their main interaction should only be information to employees, selection of a coverage level if applicable, and monthly transmission of required premiums to the Exchange or qualified health plans. As such, a SHOP Exchange's premium aggregation function will limit the administrative burden on qualified employers by allowing them to write just one check each month independent of the number of QHPs for which their employees are enrolled.

We recognize that the proposal in section 155.705(b)(3) allows employers to limit employee choice to just a single QHP affords flexibility to employers, but we are concerned that this provision will result in decreased employee choice. Because employers are already allowed to make one payment independent of the number of QHPs in which their employees enroll, we believe that there is limited, if any, benefit in allowing employers to limit their employees to just a single QHP. Further, allowing employers to enroll their qualified employees into a single QHP

will trigger application of the Employee Retirement Income Security Act (ERISA). The Affordable Care Act was intended to supersede ERISA and provide stronger federal and state protections to consumers.

Recommendation 5: Navigators should include at least one community and consumer-focused nonprofit organization and be required to reach out to certain hard to reach populations.

We strongly support the requirement of section 155.210(b)(2) of the proposed rule that an Exchange must provide Navigator grants to at least two of the listed categories. Ensuring that Navigators represent different types of organizations will increase the opportunity for consumers from a broad range of backgrounds and affiliations to obtain information about the Exchange. In response to your specific request for comment, we urge the Department to require that at least one of the required two types of entities serving as Navigators be a community and consumer-focused nonprofit organization. Having representatives of this type of organization serve as Navigators will enable the Exchange to capitalize on the preexisting expertise of these groups to reach the Exchange's target audience: consumers.

We recommend that the Department increase the duties of Navigators, listed in section 155.210(d), to include a requirement that Navigators reach out to certain hard to reach populations such as limited English proficient communities, rural communities, and racial and ethnic minority communities. This requirement would increase the Exchange's ability to enroll members from these populations by providing one more avenue to disseminate information throughout these communities. Additionally, the Department should expand the requirement of section 155.210(d)(5) to require Navigators to provide information that is also simple and easily understandable to ensure optimal comprehension of the information.

Recommendation 6: Stand-alone dental plans should be required to comply with any QHP certification requirements and consumer protection standards.

With regard to stand-alone dental plans, you specifically ask for comment as to whether these plans should be required to comply with any QHP certification requirements and consumer protection standards. We strongly support extending these standards to stand-alone dental plans. Excluding them would run contrary to the very reason for Exchanges – to create fair, transparent marketplaces where consumers can shop for coverage. We also agree with your assessment that if user fees are required by any Exchange, such fees should apply to stand-alone dental plans as participants in the Exchange. Finally, we agree with your concern that requiring all insurers to separately price and offer dental benefits from medical benefits is too heavy an administrative burden for Exchanges and insurers. We fear such a requirement could reduce the number of insurers that choose to offer pediatric dental benefits, thus requiring families to purchase two

separate plans to meet their health needs. Even worse, it could result in children not obtaining pediatric dental benefits at all.

Recommendation 7: Strengthen conflict of interest standards for Exchange governing boards.

The proposed regulation limits the extent to which individuals with conflicts of interest can sit on the governing board of State Exchanges, requiring that a majority of voting members may *not* be health insurance issuers, agents, or brokers, or any other individual licensed to sell insurance. We appreciate the effort to limit conflicts of interest; however, given the important role that governing boards will play and the need for the Exchanges to regulate and negotiate with insurers, we encourage you to strengthen this provision. We recommend that you take steps to strengthen this requirement by requiring states to pursue advisory boards rather than voting representation for conflicted members on the governing board. Alternatively, we encourage you to adopt policies already used by the National Association of Insurance Commissioners with regard to participation, voting, and transparency by board members with particular conflicts of interest. We would also urge you to consider restrictions on employment with industries that profit from the Exchanges for voting members for a reasonable time after leaving the governing board.

Recommendation 8: Payments by qualified health plans to Federally Qualified Health Centers must be at least equal to payments under the Medicaid PPS System.

Under current Medicaid, Medicare, and CHIP law, Federally Qualified Health Centers (FQHCs) are paid at least what the Medicaid Prospective Payment System requires. Section 1302(g) of the Affordable Care Act extends those rules to apply to QHPs' payments for FQHC care, regardless of whether the care is provided in-network or out-of-network. These rules are designed to prevent federal Public Health Service Act grant funds from cross-subsidizing other payors.

The Preamble suggests that a later provision in the Affordable Care Act regarding essential community providers (Section 1311) confuses this clear rule. We disagree. Section 1311 requires that plans include essential community providers (where available) that serve low-income people. That requirement, however, does not mean that these providers have to be accepted as part of the plan's network if they do not agree to the plan's payment rates. But plan payments to FQHCs must be at least the rates paid by Medicaid, regardless of whether the FQHC is in-network or not. If a plan proposes not to include an FQHC that wishes to join the plan's network, however, it should by another means have the capacity and willingness to serve its low-income, medically-underserved beneficiaries without becoming a free rider on the FQHC's requirement to treat all those in need.

Conclusion

We greatly appreciate the opportunity to offer these comments and applaud your ongoing efforts to implement the Affordable Care Act in a timely and effective manner. We all want to see the Exchanges provide the utmost in "choice, clout, and competition," and as such we strongly encourage you to consider these recommendations as you balance the need for state flexibility with the great desire we all share to protect consumers.

Sincerely,

SANDER LEVIN
Member of Congress

GEORGE MILLER
Member of Congress

HENRY WAXMAN
Member of Congress

PETER STARK
Member of Congress

ROBERT ANDREWS
Member of Congress

FRANK PALLONE
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JOHN DINGELL
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Cc: The Honorable Hilda Solis, Secretary
U.S. Department of Labor

Cc: The Honorable Timothy Geithner, Secretary
U.S. Department of the Treasury