



October 31, 2011

Donald M. Berwick, MD, MPP  
Administrator  
Centers for Medicare and Medicaid Services  
Attention: CMS-9974-P  
Department of Health and Human Services  
P.O. Box 8010  
Baltimore, MD 21244-8010

**Re: Exchange Functions in the Individual Market: Eligibility Determinations;  
Exchange Standards for Employers (CMS-9974-P)**  
Submitted electronically to <http://www.regulations.gov>

Dear Dr. Berwick:

The Alliance of Community Health Plans (ACHP) is pleased to submit comments on selected provisions of the July 15, 2011 proposed rule on “Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers.”

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations that collectively provide health care and coverage for more than 16 million Americans, predominantly in the individual and small and mid-sized group markets. ACHP members provide commercial coverage and have a significant presence in the Medicare Advantage market; many also contract with their states to provide coverage to Medicaid beneficiaries. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems. Member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

ACHP commends the Department and CCIIO for developing the proposed rules implementing the ACA in a timely manner. We appreciate the difficulties the Department faces in balancing the desire for simplicity and transparency in the eligibility determination process with the responsibility of ensuring that individuals receive only those benefits to which they are entitled. And we share your commitment to reducing the likelihood of lapses in coverage and unnecessary “churning” of coverage, particularly among the more vulnerable populations.

Provisions of this NPRM will affect administrative complexity and cost, and the ability and willingness of health plans to actively participate in the development of a vibrant, sustainable insurance marketplace. Ultimately, the rule’s impact will be on the availability of coverage options to consumers and the costs they will incur. To the extent that participating health plans face lost

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revenue, providers face unpaid claims, and administrative demands become more complex, costs to consumers will increase. We urge the Department to address this concern by developing consistent and clear policies that will minimize administrative complexity and exposure to lost revenue.

Our comments focus on issues related primarily to changes in eligibility status and potential complications of other eligibility provisions in the proposed rule.

**Verification process related to eligibility for enrollment in a QHP through the Exchange (§155.315)**

The proposed rule requires that individuals being screened for eligibility to purchase through the exchange (i.e., citizenship, legal status, residency, and incarceration status) be given a 90-day period during which they may resolve discrepancies in information provided to the exchange. These individuals would, in the meantime, be granted any tax credits and subsidies that their income status would otherwise entitle them to and would be eligible to enroll in the QHP of their choice. We agree that these individuals should have coverage, but we believe this provision subjects plans to a significant risk that those who are subsequently deemed ineligible to use the exchange will fail to pay premiums and cost-sharing obligations. Given that they will have been determined unable to prove citizenship, legal status, residency or that they are not incarcerated, we believe it will be extremely difficult for plans to collect these costs. There should be clear notification by the exchange to enrollees that their enrollment is provisional based on pending verification of eligibility and that they are responsible for premiums and cost-sharing during this period. CMS should consider other means of minimizing potential health plan losses related to the time period in which eligibility is verified.

**Eligibility redetermination during a benefit year (§155.330)**

Under the provisions of subsection e(3) of this section, a subsidized enrollee who is found to have become ineligible for continued enrollment during the coverage year is automatically given what is, in effect, a two-month period of continued eligibility. However, the individual does not receive tax credits and subsidies they had previously been receiving. We believe this creates a scenario in which it is likely that the now-unsubsidized individual, facing a large increase in costs, could continue coverage for the two-month period but stop paying some or all of their premium or cost-sharing responsibilities, leaving the plan to absorb that loss. ACHP suggests a *de minimus* threshold for income changes; only above that level would an eligibility redetermination be triggered. We also suggest consideration of how navigators, exchanges, and others can communicate to enrollees their payment responsibilities, and we encourage CMS to consider additional means of addressing this problem.

**Eligibility determination process (§155.310)**

The proposed rule requires that an exchange allow an individual determined to be eligible for an advanceable premium tax credit to accept less than the full amount of advance payments of the premium tax credit for which they are determined eligible, in order to be sure they do not owe money at the end of the year. We recognize and appreciate the Department's stated goal of minimizing the amount of reconciliation that an individual may face for excess credits, but we do not believe this is an appropriate mechanism for meeting this goal. Rather, as with the provisions discussed above, the additional premium burden faced by these individuals (above what the government has otherwise determined they are able to afford) creates a greater likelihood that

premiums and/or cost-sharing obligations will go unpaid or underpaid. We suggest that advance payments of the tax credit should closely match the amount for which the individual is eligible.

ACHP strongly agrees that regulations should provide for continuity of coverage to the greatest extent possible. Without taking away from that goal, we urge the Department to carefully consider provisions that may increase some consumer costs by making it more likely that premiums and cost-sharing will be unpaid. This is particularly important given the uncertainty around the proposed rules on termination of coverage and the three-month grace period (Sec. 156.270). ACHP raised questions about those provisions in our response to the proposed rule (CMS-9989-P) on exchanges and Qualified Health Plans.

In addition to these concerns, we offer a comment on one other provision in the proposed rule that could pose difficulties for consumers living in a different area from the primary taxpayer.

**Eligibility standards (§155.305)**

Section (a)(3)(iv) of this portion of the NPRM allows a spouse or a tax dependent, residing outside the service area of the primary taxpayer's exchange, the option of either enrolling in a plan offered through the primary taxpayer's home-state/region exchange or purchasing through the exchange in the location where they reside. We are concerned that a person who purchases coverage from a plan offered through an exchange where they do not live would likely encounter difficulties in finding care as well as significant additional costs from the use of out-of-network providers. In addition, the health plan would be limited in its ability to facilitate use of the highest quality and most efficient providers and coordinate care across providers and settings. We encourage CMS to consider limiting this option and requiring spouses/dependents to purchase through the exchange in the area in which they reside.

Thank you for the opportunity to comment on the proposed regulations. We appreciate your consideration of our views.

Sincerely,



Patricia P. Smith  
President and CEO