



October 20, 2011

Donald M. Berwick, MD, MPP  
Administrator  
Centers for Medicare and Medicaid Services  
Attention: CMS-9989-P  
Department of Health and Human Services  
P.O. Box 8010  
Baltimore, MD 21244-8010

**Re: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans (CMS-9989-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 “Establishment of Exchanges and Qualified Health Plans.”

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 have a significant presence in the Medicare Advantage market and 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’s comments are shaped by our members’ commitment to Triple Aim goals: improved experience of care, improved population health and lowered costs. ACHP and its members support the establishment of state exchanges that make available to individuals and small employers a choice of Qualified Health Plans (QHPs) meeting rigorous standards. ACHP appreciates CMS’ recognition that its rules for exchanges and QHPs should be guided by the fact that states have a great deal of experience in regulating private health plans, and that plans in turn have experience in serving enrollees within the framework of their state regulatory structures. Individuals and small businesses will be best served by building on that experience, with adaptations as necessary to achieve the policy directions of the Affordable Care Act (ACA).

**MAKING HEALTH CARE BETTER**

### **Aligning rules inside and outside the exchange**

As an introductory comment, ACHP emphasizes the importance of rules that apply similarly in the exchange and the non-exchange market. This alignment of requirements will be a critical factor in determining both the affordability of coverage offered in the exchange and the ability of health plans to offer competitive products in the exchange. State requirements should apply both to Qualified Health Plans offered in the exchange and products offered outside the exchange. Where this rule establishes additional requirements, or there remain differences between rules for coverage in and out of the exchange, states should be required to demonstrate that those differences will not materially affect the competitiveness of products offered in the exchange, or otherwise indicate how they will take corrective action.

### **Entities eligible to carry out exchange functions (§155.110)**

CMS requests comment on whether the final regulation should provide further specification on categories or types of representatives who should be presumed to have a potential conflict of interest (beyond health insurance issuers, agents, brokers, or any other individual licensed to sell health insurance). This provision reflects the requirement that members of these categories must not make up a majority of the overall membership of an exchange's governing board. This section also requires that an exchange develop a policy for the public disclosure of financial interests of board members.

States should put in place policies for the disclosure of any material conflicts of interest, but ACHP believes that the expertise that health plans would bring to the governance of an exchange is essential to developing and maintaining a viable, sustainable marketplace. State policymakers in Hawaii, Oregon and West Virginia have explicitly authorized the participation of individuals employed by insurers on exchange boards (with Hawaii and West Virginia requiring representation from the carrier community). The Colorado exchange includes insurance industry leaders on its board.

Additionally, we suggest that an overly burdensome disclosure requirement for exchange board members runs the risk of depriving states of the talents and experience of the most qualified citizens. An alternative to excessive disclosure requirements, already included in several state laws establishing exchanges, would require a board member to recuse himself or herself from consideration of any matter in which the individual may have a direct financial interest.

CMS also invites comments on the types of representatives that should be on exchange governing boards to ensure representation of consumer rights and inclusion of necessary technical expertise to ensure successful operations.

ACHP recommends that CMS consider inclusion of the following, additional criteria for expertise of governing board members:

- Experience with patient-centered medical home models, accountable health care delivery, patient care coordination, integrated delivery systems, and the development of financial relationships between insurers and providers;
- Knowledge of health plan administration, finance, marketing and infrastructure;

- Experience implementing and utilizing advanced health information technology;
- Actuarial skills;
- Health law experience;
- Experience with the public health care delivery system;
- Knowledge of adverse selection issues and remedies.

### **Establishment of a regional exchange or subsidiary (§155.140)**

CMS requests identification of any operational or policy concerns with establishing multi-state exchanges or exchanges that cross state lines, specifically for regions near state borders.

In response to last year's Request for Comments Regarding Exchange-Related Provisions, ACHP recommended that in the early stages of exchange implementation, the focus should be on making state exchanges work *versus* expanding exchanges to cross state lines. Since that time, the complexity of establishing an exchange has only become more apparent. We reiterate our belief that the challenges states will face in the early stages of exchange implementation are great enough that the launch of multi-state exchanges should be delayed until a future date.

### **Financial support for continued operations (§155.160)**

The July 15 proposed rule seeks comment on whether the final regulation should limit how and when user fees may be charged to plans.

Although ACHP believes that states should be authorized to design a financing mechanism that works best for their unique market considerations, we are also concerned that excessive user fees will hinder the competitiveness of exchange offerings in relation to the non-exchange market. Similarly, if insurers are assessed a fee, the federal government should not set the timing of those assessments; we recommend that language be included in the final rule that requires states to consult with insurers and other stakeholders in the course of setting the timing and utilization of these fees. User fees should be limited to the support of exchange functions and should not be used to finance other state functions such as determination of eligibility for public programs. Also, we do not believe that the fee structure should be used to build up an emergency reserve or a "rainy day" fund.

### **Required consumer assistance tools and programs of an exchange (§155.205)**

CMS asks for guidance on how states can streamline and prevent duplication of effort by the exchange call center and QHP issuers' customer call centers.

Exchanges should have a distinct but limited role in the customer service process. In general, the exchange call center should handle issues raised during pre-enrollment, while the call center of the QHP should be the primary resource for consumers with questions about specific benefits or coverage policies of the plan in which they have enrolled, as well as billing questions (which are usually handled by the same customer service center). The staff of the exchange customer call center should be well-trained and states should explore the licensing of these representatives, in line with current state practice for insurer call center personnel. Recognizing that the exchange will sometimes receive calls that require referral to the QHP call center, and vice-versa, these referrals

must be done on a direct, person-to-person basis, rather than through provision of the QHP phone number or patching through to that number without reaching a live operator.

**Ability of States to permit agents and brokers to assist qualified individuals, qualified employers or qualified employees enrolling in QHPs (§155.220)**

CMS seeks feedback on functions that existing, web-based entities could perform on behalf of the exchange, specifically asking how such entities would interact with the exchange and what standards should apply to an entity performing functions in place of, or on behalf of, an exchange.

ACHP believes that existing web-based entities, be it HealthCare.gov or others, must provide for a robust comparison of quality, value and coordination of care in order to be considered for inclusion as part of an exchange solution. They should offer consumers the ability to sort options based on criteria that are most important to them and to map provider networks in a given plan. By way of example, the Wisconsin Exchange prototype (<https://exchange.wisconsin.gov>) allows for the sorting of choices by the following categories:

- High Overall Quality of Care;
- High Quality for your Health Conditions;
- Your Doctors Included;
- Your Hospitals and Clinics Included;
- Low Monthly Premium;
- Low Out-of-Pocket Expense;
- Good Customer Service.

Whatever tools are provided for these purposes should allow for a link to the provider’s website – as is also the case in the Wisconsin Exchange prototype.

**Payment of premiums (§155.240) and Functions of a SHOP (§155.705)**

CMS requires in §155.240 that a SHOP exchange must accept payment of an aggregate premium by a qualified employer and may facilitate through electronic means the collection and payment of premiums. In §155.705, the proposed rule requires that an employer purchasing coverage through the SHOP exchange must be provided a single monthly bill in the amount of their share of all employee premium costs and pay a single monthly amount to cover these costs. CMS anticipates, but does not require, that SHOPS will aggregate employer and employee shares as a service to employers.

ACHP recommends that aggregation should be a minimum required function in both the AHBE and SHOP exchanges. If aggregation of federal subsidies and credits is not possible in the AHBE, exchanges should be authorized to act as a “virtual aggregator.” Under this scenario, the exchange would establish essentially a “notional account” for each individual, collect premium payments from the individual, and aggregate them with the value of applicable tax credits. The exchange would then make the premium payment to the insurer, while simultaneously notifying IRS and triggering the real-time release of funds, as well as providing the appropriate notional account balance to the insurer. This would facilitate the insurer’s ability to match IRS subsidies with the insured individual via an automated process.

Given the complexity of payment flows, we think that this is a critical function for exchanges. However, if HHS determines that a virtual aggregator solution is not possible, another approach would be for the Department to make clear that, if an exchange chooses to do so, it can require, as a condition of participation, that issuers assign advance premium tax credits for individuals they cover to the exchange or to a source assigned that function on behalf of the exchange.

### **Enrollment of qualified individuals in QHPs (§155.400)**

CMS solicits input on whether the final regulation should codify a specific frequency for communication of enrollment transactions from the exchange to insurers (such as in real time or daily).

ACHP recommends that the final rule include a requirement that enrollment transaction information be processed from the exchange to the insurer at least once every 24 hours, with the expectation that the exchange will eventually move to “real time” communication of this information.

### **Initial and annual open enrollment periods (§155.410)**

In proposing specific dates for the inaugural open enrollment period and subsequent annual open enrollment periods for exchanges, CMS requests comments on the appropriate length of the initial and annual open enrollment periods for an exchange.

ACHP supports the initial open enrollment period from October 1, 2013 through February 28, 2014. However, the proposed annual enrollment period from October 15 through December 7 raises concern that this relatively long period could invite adverse selection. We recommend that the Department consider an annual enrollment period of 30 days and no more than 45 days and monitor this carefully for potential changes in the future. Also, CMS should consider allowing exceptions for states already operating exchanges that may have a different enrollment schedule.

### **Termination of coverage (§ 155.430)**

The draft rule proposes the following conditions for termination of coverage:

- The enrollee is no longer eligible for coverage in a QHP through the exchange;
- The enrollee becomes covered in another policy that provides minimum essential coverage;
- Payments of premiums for coverage of the enrollee cease, provided that the grace period required by §156.270 has expired;
- The enrollee’s coverage is rescinded in accordance with §147.128;
- The QHP terminates or is decertified as described in §155.1080;
- The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period

ACHP is concerned that certain provisions in the proposed rule could be manipulated, intentionally or unintentionally, to allow individuals to receive coverage on a virtually continuous basis while failing to make premium payments. For example, an individual could purchase coverage, pay premiums for several months, stop paying premiums and continue coverage through the “grace period.” Should that grace period coincide with the open enrollment period, the individual could

enroll in another plan and begin the same cycle. One possibility to address this problem would be for the exchange to maintain a list of individuals who are in arrears to a QHP offered through the exchange and require that the person settle their account before being allowed to join another plan. See our comments on §156.270, below, for more on this topic.

### **Functions of a SHOP (§155.705)**

Central to the concept of an exchange and, we would argue, critical to the success of the ACA is the expansion of coverage choices available to consumers. Accordingly, we strongly support the provision in Section 155.705(b)(2) that employees can select from any Qualified Health Plan in the SHOP exchange within the coverage (“metal”) tier offered by their employer. This will give employees of small firms coverage choices that they have not had in the current market and encourage competition among issuers. Importantly, employee choice of plan allows the employee to choose the provider network and specific providers that best meet his/her needs and increases the chance that the employee can maintain continuity of care through job changes. In turn, this is likely to strengthen development of partnerships between health plans and their provider networks.

We believe another provision of the proposed rule would be contradictory to the goal of expanding coverage choices. Allowing an exchange to interpret “subscriber choice” as meaning that an employee could choose among coverage options offered only by an issuer designated by the employer would undermine the intent of the ACA to expand consumer choices. We suggest that this provision contradicts the statutory language in Section 1312(a)(2), providing for employees of small businesses to choose any QHP within the metal tier selected by the employer.

CMS invites comment on whether QHPs offered in the SHOP should be required to waive application of minimum participation rules at the level of the QHP or issuer; whether a minimum participation rule applied at the SHOP level is desirable; and if so, how the rate should be calculated, what the rate should be, and whether the minimum participation rate should be established in Federal regulation.

ACHP believes that the SHOP should be allowed to impose minimum participation requirements, with waiver provisions similar to those in current state laws.

Also in this section, CMS asks whether the timeframe in which plans can change rates (monthly, quarterly or annually) should be more permissive or more restrictive than currently proposed.

ACHP believes that the timeframes in the proposed rule are sufficient and should not be made more restrictive in the final rule. An exception should be made for rate changes that result from federal and state legislative or regulatory actions; states currently provide for these periodic rate changes outside the normal timeframes when state policy changes dictate a modification in previously approved rates.

### **Enrollment periods under SHOP (§155.725)**

The proposed rule includes a “rolling enrollment” policy under which employers may begin participating in the SHOP at any time during the year. The plan year would begin on the first day of an employer’s effective date of coverage and last 12 months.

While the extension of a rolling enrollment period for all businesses joining the SHOP exchange could create significant administrative and logistical problems for insurers, ACHP understands the importance of this policy in drawing participation and ensuring the long-term stability of the SHOP. We suggest, however, that the effective date of coverage for employees be the first day of the next month following the date of enrollment. If enrollment takes place after the 20<sup>th</sup> of the month, the effective date should be the first day of the second month following the date of enrollment; for example, enrollment on June 25 becomes effective on August 1.

### **Certification standards for QHPs (§155.1000) and Certification process for QHPs (§155.1010)**

CMS proposes in §155.1000 to provide exchanges with discretion to determine whether offering a QHP is in the best interest of eligible individuals and employers. CMS notes that exchanges may adopt an “any willing plan” model or a more active purchaser role, such as through the use of selective contracting, competitive bidding, or case-by-case negotiations. In §155.1010, CMS proposes to codify that a multi-state plan approved by the U.S. Office of Personnel Management is exempt from the certification process and is deemed to meet the certification requirements.

ACHP is concerned that the language on “best interest” is not defined and potentially subject to misuse if it excludes health plans that otherwise meet the statutory requirements for qualification as a QHP. We have consistently advocated for high standards for QHPs, particularly as they relate to quality and service for enrollees; exchanges should include all QHPs meeting those standards. If CMS is to allow exchanges to pursue other models, ACHP recommends that CMS formulate criteria that exchanges must use in defining the “best interests” of qualified individuals and employers. Both states and CMS will have to monitor situations in which some QHPs are excluded from offering coverage in the exchange, to assure choice and access to high quality plans and services.

In order to assure a level playing field in any such selective purchasing approaches, CMS should find a way to waive the special protections and deemed status accorded multi-state plans. If exchanges decide to select among QHPs that otherwise meet requirements, or negotiate with such plans, they cannot at the same time admit a limited number of large, multi-state QHPs who would not be subject to the same requirements and decision-making process. This could well put at a competitive disadvantage community-based and state and regional plans, many of which have been the cost, quality and service innovators that have served their communities for decades. Consumers choosing among QHPs in the exchange should know that all of their choices meet one set of rigorous standards.

### **QHP issuer rate and benefit information (§155.1020; §156.120)**

CMS proposes that exchanges require (§155.1020) and QHP issuers submit (§156.120) rate and benefit information, including justification of rate increases, and that QHPs prominently post such justifications on their websites. Further, exchanges are required to consider the rate justification, as well as excess growth in rates outside the exchange, in certifying plans. Finally, issuers must set rates for the entire benefit year, or plan year in the case of the SHOP exchange.

ACHP appreciates CMS’ recognition that most states already operate effective rate review programs; CMS has established extensive rate review requirements in the final rule implementing

the rate increase disclosure review requirements mandated by Section 2794 of the Public Health Service Act. CMS notes in the proposed rule that it seeks to avoid duplication with other requirements. ACHP recommends that CMS clarify in the final rule that, where the State has been found to have an Effective Rate Review Program under §154.301, the exchange must rely on that state process. That is the best way to prevent burdensome duplication that will be confusing for consumers. Further, ACHP recommends that issuers only be required to submit a rate justification for those rates that are subject to review under Section 2794. Under the associated regulations finalized at §154.200, review of increases and requirements for rate justification are limited to rate changes of 10 percent or more, or otherwise exceeding a state-specific threshold to be determined by the Secretary.

ACHP recognizes that CMS is codifying statutory requirements in requiring exchanges to consider the rate justification, as well as the issuer's rate increases, outside the exchanges in certifying health plans. But ACHP notes that exchanges are also required to collect and disseminate quality and service information on QHPs; we recommend that CMS require that exchanges actually take that information into account (as well as the premium rate information) in certifying health plans. Incorporation of the quality and service measures would further reinforce CMS' stated commitment to incentives that achieve better care, better health, and lower costs.

Finally, while ACHP supports the policy that QHP issuers set rates for a benefit year or plan year, ACHP recommends that an adjustment to the rates be allowed in cases where changes in state or federal law or regulation impose a previously unanticipated requirement that increases QHP costs during that year.

### **Rating variation (§156.255)**

CMS proposes four family categories for purposes of rating: individual, two adults, one adult with children, and all others. CMS further proposes that QHPs may combine the categories, for example by combining the category of one adult with children with the category for all others, and asks for comment in a number of areas.

ACHP generally supports those four categories but notes that these standards should apply to rating both inside and outside the exchange. However, allowing flexibility to combine the rating categories raises some concerns; for example, combining the categories may exacerbate risk selection and consumer confusion, especially in the early years. We also note that the flexibility for QHPs to use separate or combined family rating categories may complicate the computation of the premium tax credit under the rules proposed by the Department of the Treasury on August 22, 2011. Those rules provide that the tax credit is computed based on the premium for the benchmark plan, which is the second lowest-priced "silver" plan for that taxpayer's family enrollment category in the exchange. If some QHPs use the four listed rating categories, and others combine them in different ways, it is not clear how the "benchmark" calculation would be made for the taxpayer's family enrollment category.

### **Network adequacy standards (§155.1050; §156.230)**

CMS proposes in §155.1050 that exchanges set network adequacy standards that are appropriate to State and local standards of care, with a general requirement that the “provider network...offers a sufficient choice of providers for enrollees.” CMS proposes in §156.230 that QHPs comply with the standard the exchange sets, as well as comply with essential community provider requirements and the existing network adequacy provisions in Section 2702(c) of the Public Health Service Act.

CMS asks for comments on whether additional criteria would be useful, including in particular standards that are based on the Managed Care Plan Network Adequacy Model Act developed by the National Association of Insurance Commissioners (NAIC). States have a long history in setting and implementing standards for network adequacy, including state use and adaptation of the provisions of the Model Act. For that reason, we agree with the proposed rule that exchanges set network adequacy standards. These standards should be aligned with state standards; it is important that network requirements be the same for health plans offered inside and outside the exchange to avoid creating adverse selection between the two markets. Creation of a federal network adequacy standard, or even a separate network adequacy standard for QHPs within the exchange, could have the unintended consequence of destabilizing the exchange. We would also note that, in addition to the existing state network adequacy requirements for licensed issuers, network adequacy will be reviewed by the accreditation agencies that will be accrediting QHPs. Network adequacy is an important factor in determining health plan accreditation.

### **Essential community providers (§156.230; §156.235)**

As noted above, one of the network adequacy standards is compliance with requirements for essential community providers (ECPs). CMS requires that QHPs include within their networks “a sufficient number of essential community providers, where available, that serve predominantly low-income, medically underserved individuals.” CMS proposes to define ECPs as including those groups identified in the statute, namely those named in section 340B(a)(4) of the PHSA and in section 1927(c)(1)(D)(i)(IV) of the Social Security Act. ACHP agrees with this approach, but recommends that the Final Rule add a requirement to the definition of ECP that the entity must serve low-income, medically underserved individuals. CMS goes on to note that nothing requires the plan to provide coverage for any specific medical procedure provided by an ECP, and CMS does not propose to require QHPs to contract with all ECPs. ACHP supports these provisions.

ACHP supports CMS’ overall approach of a standard based on a sufficient number of ECPs to meet service needs, rather than requiring the blanket inclusion of all ECPs regardless of enrollees’ needs. We recommend, however, that if an exchange does opt for a more extensive regulatory requirement to include all ECPs, it do so only if the exchange can demonstrate that the requirement is based on a rigorous and open assessment of the service and delivery needs of low-income, medically-underserved individuals in the area served by the exchange.

CMS notes that it is considering how to adapt its ECP policy for integrated delivery system network health plans; ACHP strongly supports such an adaptation. This raises issues that are significant for some of the leading delivery system-oriented plans in the nation.

The first is the definition of such network plans. CMS suggests in the proposed rule that an option is to include plans where services are delivered solely “in house,” including employees or an exclusive contracted arrangement. We suggest two revisions. First, even the most highly integrated plans rely on out-of-network hospitals for emergency care and may send patients to centers of excellence for specialized services; these exceptions should be recognized.

Second, ACHP’s experience in the evolving market is that the definition of an integrated system should be broadened to include plans and delivery organizations that have strong but not necessarily exclusive arrangements. For example, there are high-performing health plans which employ or exclusively contract with physicians that may cover significantly more than half of all enrollees, particularly in a core urban area (where the percentage of enrollees cared for by these physicians would be even higher). These plans then contract with physicians in less populated areas to extend their service delivery area. We believe that these plans should be considered integrated systems for purposes of the ECP exemption. Similarly, we suggest that CMS also broaden the definition of an integrated delivery network plan to include plans that can demonstrate that a majority of primary care for their enrollees in an exchange is provided by provider groups that, in turn, have a significant percentage of their patients covered by that plan. We suggest that CMS consult with stakeholders to specify these percentages.

Once defined, the issue is what ECP policy to suggest for such plans. CMS notes several options, including an exemption, or an exemption contingent on meeting some other standard, such as evidence of services delivered to low-income populations, compliance with national standards for culturally and linguistically appropriate services, or implementation of a plan to address health disparities. ACHP would support an exemption given the structure of these plans in serving enrollees; the plan should provide evidence of the availability “in house” of the health plan’s services for the low-income and medically underserved population that is the presumed policy target for the ECP provision. ACHP believes that all plans and providers should be proceeding with efforts to address disparities as well as providing culturally and linguistically appropriate services.

One final issue that CMS raises in the proposed rule relates to payment to ECPs. CMS seeks comment on conflicting payment provisions in the ACA. One section provides that a QHP is not required to contract with an ECP or an Indian Health Service (IHS) provider if the provider refuses to accept the plan’s generally applicable payment rates. Other statutory provisions require QHP issuers to pay federally qualified health centers (a subset of the ECP community) at Medicaid rates; and IHS providers have the right to recover amounts up to the higher of reasonable charges or the insurer’s highest payment rate.

ACHP appreciates CMS identifying this conflict and supports the option identified by CMS of permitting issuers to negotiate mutually agreed payment rates, so long as those rates are at least equal to the plan’s generally applicable payment rate.

### **Service area (§155.1055)**

CMS proposes that exchanges have discretion in defining service areas, and does not require that a service area be statewide. We agree with this approach, but urge that the Final Rule prohibit an exchange from mandating that a QHP serve the entire state. Mandating statewide coverage would discourage the development of QHPs that are closely aligned with their provider networks. In many

cases, these providers are based in a specific geographic locality and would not have the network to serve all areas of a state.

In defining service areas, exchanges would be subject to two requirements:

- The service area must cover a minimum area that is at least a county or group of counties, unless the exchange determines that a smaller area is necessary, non-discriminatory, and in the best interest of qualified individuals and employers.
- It must be established without regard to specific discriminatory factors identified (race, ethnicity, language, health status factors), or other factors that exclude high use, high cost or medically underserved populations.

ACHP supports the discretion given exchanges and the need to assure that service areas are not defined in a manner that is in any way discriminatory according to the factors identified by CMS. ACHP is concerned, however, that the so-called “county integrity” rule should not be included as an additional standard. That is but one mechanism, and a more arbitrary one, to achieve the anti-discrimination objectives. Decisions made by the exchange should be consistent with service areas defined by state regulators, who currently are charged with assuring that service areas are not discriminatory. If there is concern about these state reviews, CMS could establish a process, similar to the approval of effective state premium rate reviews, to assess the adequacy of state anti-discrimination criteria.

### **Termination of coverage for qualified individuals (§156.270)**

CMS proposes standards for termination of coverage, including notice, and special rules for non-payment of premiums. For those individuals not receiving advance payment of premium tax credits, CMS proposes that the exchange must establish a standard policy that is applied uniformly to enrollees in similar circumstances.

For those who receive advance payment of premium tax credits, CMS proposes a more specific three-month grace period as required by the ACA, with special standards applying. CMS notes that the grace period applies only in the case where the enrollee initially paid at least one month’s premium, and that any premium payment during the grace period is applied to the earliest billing cycle. CMS further requires plans to continue paying for benefits during this period.

ACHP recognizes that the three month grace period is a statutory provision, but notes that there is a cost of such a provision that is spread to all other policy holders as well as to the federal government. We recommend that CMS clarify several issues related to non-payment. First, how does CMS propose to deal with partial payment prior to the initiation of the grace period? The termination process is clearly triggered if an individual pays nothing. Can it be triggered if the individual pays some, but not all, of their share of the premium?

Second, the proposed rule is unclear on what happens during the grace period in the case of an individual who makes partial payment during that period. The language of the proposed rule (§156.270(f)) states that: “If an enrollee...exhausts the grace period...without submitting any premium payment, the QHP issuer may terminate the enrollee’s coverage effective at the end of the payment grace period.” This implies that termination can occur only if no payment is received, and

that if some payment is made, even if not full payment, the grace period is extended. But in the preamble, CMS says: “The grace period will be reset only when the individual has fully paid all outstanding premiums.”

ACHP recommends that the policy be clarified so that the preamble and regulatory text are consistent, and that the grace period be reset only in the case of full payment. Otherwise, an individual can constantly remain three months or more in arrears and retain coverage, which is unfair to the other enrollees who ultimately finance that cost.

We commend CMS and particularly the CCIIO staff for the thoughtful work reflected in the proposed rule. Thank you for consideration of our comments.

Sincerely,

A handwritten signature in cursive script that reads "Patricia P. Smith".

Patricia P. Smith  
President and CEO