Public Comments on Interim Final Rule on Exchanges

(April, 2012)

SEIU Healthcare Minnesota
Dear Commissioners Jesson, Rothman and Ehlinger:

I appreciate the work being done by the Departments of Commerce, Health and Human Services and your staff to develop an Exchange that will best serve the people of Minnesota. I know that the engagement and frequent consultation between state and federal officials will ultimately result in an Exchange that meets the requirements of the ACA and addresses the specific needs of our state. Thank you for this opportunity to present comments on the Interim Final Exchange Regulations. I appreciate the ongoing efforts of the state to consult with a broad range of stakeholders and especially to keep the interests of consumers forefront among considerations in Exchange design.

1. §155.220(a)(3) – Related to the ability of a State to permit agents and brokers to assist qualified individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs

Under §155.220(a)(3), HHS clarifies that agents and brokers may assist individuals in applying for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR) for QHPs as long as they register with the Exchange, meet certain training requirements, and abide by relevant Exchange standards and state law. We understand the present market role of agents and brokers and their likely continued role in connecting small employers to the SHOP Exchange.

We are extremely concerned, however, about the extent to which agents and brokers may be allowed to mediate individuals' use of the Exchange. The final rule confirms that agents and brokers, including web-based brokers, will be allowed to assist individuals in the QHP selection process and with enrollment through the Exchange. Authorizing them to assist individuals in applying for the APTC and CSR would enable agents and brokers to mediate consumers' entire experience of using the Exchange.

Brokers and agents are often authorized representatives of health insurance carriers, and even when they are not, they may have strong relationships with carriers. Because of these conflicts of interest, a strong risk exists that some brokers may steer consumers toward plans based on considerations other than the best interests of the consumers. Individuals would be better routed to navigators with no conflicts of interest in their plan selection. While the rules clearly outline a role for brokers in the Exchange, we strongly oppose the role provided in §155.220(a)(3) as unnecessary and unfavorable for the populations the low-income tax credits are designed to serve.

Those who will be eligible for low-income APTC and CSR are likely to include hard-to-reach and underserved populations in our state. When it comes to accessing our health care system, these populations are more receptive to assistance and recommendations from groups and individuals who already have an existing relationship with their community. Trust and familiarity are critical to helping this population access and maintain health care coverage in the Exchange. Accessing these tax credits will likely be the first step in the navigator process for this population. Allowing industry brokers to have
a visible role in this step undermines our ability to better serve this population through the navigator program. Referring individuals to a navigator for assistance applying for the APTC and CSR would ensure familiarity with navigators as an alternative to agents and brokers for assistance with plan selection.

Plan comparison tools on the Exchange website will be designed to educate individuals on plan characteristics and help them choose high-value plans. This helps connect qualified individuals to the most appropriate coverage and promotes competition among plans based on value. The final rule already allows agents and brokers, including web-based brokers, to supersede this function and enroll individuals through the exchange. Enabling agents and brokers also to assist individuals in applying for the APTC and CSR, and thus to mediate consumers' entire experience with the Exchange, will make it less likely that consumers will become aware of the tools available to them on the Exchange. This concern does not apply to navigators, who should have no incentive to supplant the plan comparison tool with any other process for selecting QHPs.

Prohibiting agents and brokers from assisting individuals with the APTC and CSR will not exclude agents and brokers from playing an important role in the Exchange. Agents and brokers clearly have an existing relationship with small employers be suited for helping these employers access coverage in the SHOP Exchange, for which the APTC and CSR are not available. Not allowing them to assist individuals in the individual market with accessing their public subsidies and tax credits does not threaten their viability and role in the Exchange.

2. §155.345(a) and §155.345(g) – Related to agreements between agencies administering insurance affordability programs

A no-wrong-door approach is a key feature of the Affordable Care Act. Individuals should be able to enroll in coverage for which they are eligible, regardless of the agency, entity, or program to which they initially submit an application or the application method they use. Ensuring that state agencies and all entities involved in the Exchange are prepared to handle this complex coordination in a streamlined fashion is essential.

Under §155.345, HHS clarifies its intent to meet this requirement by maintaining a streamlined eligibility determination process for consumers. Consistent with the Medicaid final rule, HHS adds standards for how agencies administering Medicaid, CHIP, and Basic Health Plan (BHP) will transmit an application to the Exchange and how the Exchange will take the necessary steps to process such applications. These standards include: (a) not duplicating eligibility and verification findings already made by the transmitting agency; (b) not requesting information of documentation from an individual when it has already been provided to another insurance affordability program; and (c) determining eligibility for enrollment in a QHP and advance payments of premium tax credits and cost-sharing reductions promptly and without delay.

HHS has specifically requested comments on paragraphs (a) and (g) of this section. We submit the following suggestions and recommendations with respect to these provisions:

Summary of §155.345(a)
Exchanges must provide HHS with copies of any agreements made with other agencies administering insurance affordability programs upon request. These agreements include a clear delineation of the responsibilities of each program to minimize the burden on individuals, ensure prompt determinations of eligibility and enrollment, including redeterminations, and ensure compliance with paragraphs (c), (d), (e), and (g) of this section.

Comments on §155.345(a)
Clear roles and responsibilities for parties to these agreements help to ensure accountable and workable partnerships among the appropriate entities and programs. Such partnerships are important to creating
a seamless system of eligibility, enrollment, and renewal for individuals. We suggest that HHS provide clarity for these responsibilities by defining the standard to which these agreements should “minimize the burden on individuals,” as required under this paragraph, or, at a minimum, define the usage of “burden” on individuals in the Exchange in the context of these agreements. We also recommend HHS define what time period would suffice as a “prompt determination of eligibility and enrollment, including redeterminations…without undue delay” to ensure not only proper compliance by all parties to these agreements, but also timely enrollment for eligible individuals no matter what door (or entity) they choose to apply for coverage.

Summary of §155.345(g)
Paragraph (g) of this section outlines the requirements for when an individual submits an application directly to an agency administering Medicaid, CHIP, or BHP, instead of the Exchange. This paragraph requires that, in these instances, Exchanges must ensure: (1) secure data transmissions; (2) no duplicative eligibility or verification applications or findings; (3) no additional information or documentation requests of an individual; (4) a determination of eligibility for enrollment in a QHP, advance payments of the premium tax credit and cost-sharing reductions, promptly without undue delay, and (5) a streamlined process for eligibility determinations regardless of the agency that initially received the application.

Comments on §155.345(g)
To ensure a no-wrong door approach, an individual’s point of entry to the application process—the Exchange or Medicaid agency—should not affect in any way rights to prompt processing and determination of eligibility. For this reason, we suggest HHS provide further clarification of what timeline is appropriate for eligibility processes under paragraph (g), specifically with respect to its reference to determinations made “promptly without undue delay.” Preferably, this clarification would set forth a time limit for such processes that is consistent with the time limit an individual experiences when seeking coverage directly through the Exchange.

Thank you for your leadership in developing a successful Health Insurance Exchange that adheres to the fundamental principles of health reform by striving to provide access to high-quality, affordable health care for all Minnesotans. I look forward to continuing to work with you on these goals.

Sincerely,

Phillip Cryan
Health Policy Specialist and Organizing Director
SEIU Healthcare Minnesota