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October 31, 2011

The Honorable Kathleen Sebelius
Secretary of Health & Human Services
Hubert H. Humphrey Bldg., Room 120F
200 Independence Avenue, S.W.
Washington, D.C. 20201

RE: Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employees

Dear Secretary Sebelius:

National Patient Advocate Foundation (NPAF) is the voice for millions of patients who have sought care after a diagnosis of a chronic, debilitating or life-threatening illness. Its advocacy activities are informed and influenced by the experience of patients who receive direct, sustained services from its companion organization, Patient Advocate Foundation (PAF), a business that employs 212 people in 9 states. Founded in 1996, PAF is a national non-profit, 501(c)(3) direct patient services organization with a mission "to safeguard patients through effective mediation assuring access to care, maintenance of employment and preservation of their financial stability." PAF provides professional case management assistance to patients with chronic, debilitating or life-threatening conditions.

PAF serves as an active liaison between patients and their insurer, employer and/or creditors to resolve insurance, job retention, and/or debt crisis matters relative to their diagnosis through professional case managers and a national network of health care attorneys. PAF case managers work with patients and their providers to identify local, state, and federal programs that provide assistance for their individual needs, ensure appropriate reimbursement for healthcare services by their insurers and educate them on their employment rights during an illness. In 2010, PAF resolved 82,963 patient cases and received more than four million additional inquiries from patients nationally.

The comments found in the balance of this letter are informed by the collective experiences of patients, who have contacted PAF for assistance in accessing quality care. Those experiences have been quantified in the PAF's Patient Data Analysis Report (PDAR) which illustrates the data collected across 260 variables by PAF senior case managers. As noted above, PAF resolved 82,963 patient cases and received more than four million additional inquiries from patients nationally in 2010. Thus, while CMS staff will certainly review an unprecedented number of perspectives regarding the proposed regulation, NPAF's perspective is an invaluable one as it reflects the quantification of over a decade and a half of collective patient experience in health system navigation.

The proposed regulation addressing eligibility determinations for Health Insurance Exchange participation and insurance affordability programs and standards for employer participation in the Small Business Health Options Program (SHOP) is an important one as it has the potential to significantly decrease the number of uninsured citizens of the United States of America. The Congressional Budget Office (CBO) estimates that approximately 24 million people will purchase coverage through the Exchanges by 2019.¹ The Kaiser Family Foundation simulated a demographic, health status, and health utilization profile of the individuals across the nation expected to obtain health insurance coverage through the Exchanges in 2019 used the 2007 Medical Expenditure Panel Survey (MEPS).² The MEPS data revealed that about sixty-five percent of Exchange participants would be the uninsured. They have limited interaction with the health care system. Over one third of them have gone more than two years without a check-up (37%), nearly two in five did not have a usual source of care (39%), and more than a quarter had no interaction with the health care delivery system during the year at all (29%).³

Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality and other factors. When Exchanges become operational they will help enhance competition in the marketplace, improve choice of affordable health insurance and give small businesses the same purchasing clout as large businesses. NPAF encourages HHS to recognize that each of these goals can only be accomplished by active consumer participation. NPAF offers its insight in assuring that participation.

The Patient Protection and Affordable Care Act (PPACA)⁴ provides premium tax credits to be available to eligible individuals with incomes between 139% and 400% of poverty (or \$14,404 to \$43,320 for individuals) to purchase coverage through Exchanges. NPAF has significant experience serving as the voice for this population as demonstrated by the table below which stratifies patients assisted by PAF in 2010 by income ranges:

	Income of All PAF Patients in 2010	Income of Uninsured PAF Patients in 2010:	Income of PAF Medicare Patients in 2010:	Income of PAF Medicaid Patients in 2010:
Less than \$11,000:	28.73%	46.51%	16.83%	57.92%
\$12,000 - \$23,000:	34.27%	31.71%	49.24%	30.62%
\$24,000 - \$35,000:	18.11%	13.13%	20.80%	7.87%
\$36,000 - \$47,000:	8.23%	4.53%	7.37%	2.49%
\$48,000 - \$59,000:	4.30%	1.92%	2.98%	0.74%
\$60,000 - \$71,000:	2.76%	0.95%	1.26%	0.17%
\$72,000 - \$83,000:	1.41%	0.60%	0.67%	0.04%
\$84,000 - \$95,000:	0.66%	0.21%	0.20%	0.04%
\$96,000 - \$107,000:	0.58%	0.17%	0.20%	0.04%
\$108,000 - \$119,000:	0.28%	0.11%	0.14%	0.04%
\$120,000 or more:	0.69%	0.17%	0.30%	

Eligibility Determinations Concerning Residency and Familial Situations NPAF first commends HHS' work to ensure that the Exchange, Medicaid and CHIP define residency in a manner that enables a uniform eligibility determination process for the vast majority of individuals to reduce complexity and confusion. The proposed rule's approach in aligning the Exchange residency standards with the residency standards proposed for Medicaid, which include an "intent to reside" standard for individuals who are 21 years of age or older. Those who have such an intent, are seeking coverage through the Exchange and who intend to reside within the service area of the Exchange will meet the Exchange residency standards. The approach accommodates individuals who may transition between the service areas of different Exchanges, such as

¹ CBO Updated Projections on Health Insurance Coverage, Exchange Subsidies, and Enrollment in Medicare and Medicaid

² "A Profile of Health Insurance Exchange Enrollees," Kaiser Family Foundation, March 2011

³ *Ibid.*

⁴ Pub.L. 111-148

seasonal workers and individuals seeking employment in the service area of the Exchange. It also allows individuals who are temporarily absent from the service area to remain within the same Exchange during their absence. NPAF applauds HHS' accommodation of potential challenges that may preclude people from remaining in the Exchange. This approach does not only foster convenience, but promotes patient continuity of care by their healthcare providers.

NPAF is also in favor of the proposed rule's approach in accommodating differing familial situations. There may be situations in which a tax household may include members residing in different service areas served by different Exchanges. The proposed rule allows spouses or tax dependents who reside outside the service area of the primary taxpayer's Exchange, i.e. noncustodial parent claiming a child as a tax dependent, to elect one of two approaches. They may either enroll in a qualified health plan (QHP) through the Exchange that services the area in which he or she resides or intends to reside or enroll in a QHP through the Exchange that services the area in which his or her primary taxpayer intends to reside or resides. This approach is commendable as it provides flexibility to an individual who does not live in the service area of the Exchange in which his or her primary taxpayer lives but want to remain in the same Exchange as the primary taxpayer. It benefits a number of situations, particularly students attending out-of-State schools or tax dependents who do not live with their primary taxpayer. More important, it once again encourages patient continuity of care with health care providers.

NPAF Recommendations of Eligibility Determinations Concerning Residency and Familial Situations NPAF recommends the Medicaid and CHIP programs define residency in a manner that enables a uniform eligibility determination process for the vast majority of individuals to reduce complexity and confusion. In particular, Medicaid's intent to reside approach must be adopted in public programs. NPAF recommends the expansion of a broad definition of families to accommodate familial definitions, including blended families and other considerations.

Premium Tax Credit and Notification The Affordable Care Act establishes a premium tax credit and cost-sharing reductions that are available to certain individuals and allows advance payments of the premium tax credit to be made to QHP issuers on behalf of eligible individuals. NPAF is in favor of the eligibility standards or advance payments of the premium tax credit as they are reasonable. Essentially, the Exchange may determine a primary taxpayer eligible to receive advance payments if the Exchange determines that he or she is expected to have a household income of at least 100 percent but not more than 400 percent of the Federal Poverty Level and one or more applicants for whom the primary taxpayer expects to claim a personal exemption deduction on his or her tax return for the benefit year (including the taxpayer and his or her spouse) meets the standards for eligibility for enrollment in a QHP through the Exchange and is not eligible for minimum essential coverage. The Exchange may provide advance payments of the premium tax credit only for an applicant who is enrolled in a QHP through an Exchange.

NPAF Recommendations Concerning Premium Tax Credit Notification While the eligibility standards are reasonable, NPAF calls into question the ability of health consumers to fully comprehend and appreciate the many nuances of these advance payment requirements. Health consumers need to be made aware of the fact that significant health insurance coverage assistance is determined by the manner in which they complete their tax forms. NPAF therefore encourages HHS to partner with the nonprofit community, particularly the patient advocate nonprofit community in educating health consumers about the nexus between tax form completion and premium tax credit/cost-sharing eligibility. HHS should establish a grant program for patient advocates to perform this important responsibility.

The income eligibility requirement differences for Medicaid/CHIP and advance payment of the premium tax credit may create difficulties for individuals who suffer substantial decreases in income during the benefit year. Eligibility for Medicaid and CHIP is based on current income while eligibility for the premium tax credit is based on annual income. Unlike Medicaid and CHIP, the premium tax credit is paid on an advance basis and then reconciled based on information reported on an individual's tax return for the entire year. It is possible that an individual may receive advance payments of the premium tax credit based on an initial eligibility determination at 150 percent of the FPL and his or her actual annual household income reported on the tax return is 300 percent of the FPL. In that case he or she will be liable to repay advance payments of the premium tax credit to reduce the credit to the 300 percent level. HHS suggests a strong initial

eligibility process to decrease the difference between the amount advance payments and the premium tax credit amount based on actual income at the end of the year and invites comments on how this may be accomplished.

Eligibility Process Medicaid and CHIP beneficiaries are likely to be confused by the vast differences in eligibility between these programs and the premium tax credit program. The statutory reconciliation process may also make coverage unaffordable for some.

NPAF Recommendations Concerning Eligibility Processes NPAF suggests HHS assure the strong initial eligibility process is not one that is punitive in nature. Health consumers may experience changes in income that are not foreseeable. NPAF also repeats its encouragement to HHS to benefit from the strong trust health consumers place in the nonprofit community by relegating the strong initial eligibility process responsibility to the nonprofit community. While health consumers may be reluctant to divulge their confusion to government representatives, the nonprofit community is accustomed to determining health consumer level of understanding and can work with the consumer to elevate comprehension. Moreover, the nonprofit community has expertise in creating educational campaigns designed at the income levels eligible for Exchange participation. NPAF encourages HHS to allow reconciliation to take place allowing payment in reasonable installments spread out over time. NPAF believes it is imperative for HHS to adopt its recommendations because, as noted in the proposed regulation, large repayments due to reconciliation after an increase in income could deter enrollment. This result, coupled with a reconciliation process that renders coverage unaffordable for individuals who have substantial decreases in income during the benefit year could result in lower participation and a negative impact on the Exchange risk pool. Either of these results could serve to frustrate Exchange viability.

NPAF supports the proposed regulation's eligibility determination process. The requirement to have Exchanges consider an applicant's eligibility for Medicaid and CHIP as part of an eligibility determination for advance payments of the premium tax credit is important, particularly in states where the changes to minimal essential coverage will expand drastically as a result of the PPACA. NPAF also appreciates HHS' recognition of a health consumer's unforeseen change in financial circumstances by allowing Exchanges to accept an application and make an eligibility determination at any point in time during the benefit year. The relevant sections of the proposed rule which require Exchanges that determine an applicant is eligible for Medicaid or CHIP to notify the State Medicaid or CHIP agency and transmit relevant information, including information from the application and the results of verifications, to such agency promptly and without undue delay in order to enable the applicant to receive benefits should require Exchange attestations and include penalties for Exchanges that repeatedly fail to satisfy this requirement. NPAF notes that health consumers who receive advance payments must first attest that he or she will meet the tax-related provisions, such as one requiring him or her to claim a personal exemption deduction on his or her tax return for the applicants identified as members of his or her tax family. Also, in situations where an application filer who is not the primary taxpayer completes the application process on the primary taxpayer's behalf, the primary taxpayer must actively attest that he or she will comply with the standards for advance payment. NPAF believes there ought to be mutuality of obligation regarding attestations between Exchanges and health consumers relative to efficient Exchange operations.

NPAF notes that the section of the proposed regulation regarding the verification process related to eligibility for insurance affordability programs would be improved if it included requirements for the Exchange to educate health consumers on that process. An individual who is eligible for minimum essential coverage is ineligible for advance payments of the premium tax credit. At the time of eligibility determination, the health consumer should be informed that he or she should notify the Exchange if subsequently informed of program ineligibility by the agency administering the relevant minimal essential coverage program. It is likely the coordination between Exchanges and minimal essential coverage program agencies will encounter challenges before they operate seamlessly. While the problems with coordination may be viewed as administrative inconvenience for them, these problems represent the difference between having access to healthcare or not having access even if so entitled. The health consumer should also be encouraged to notify the Exchange if he or she experiences a change in their income status as that will likewise directly affect their eligibility status.

HHS invites comment regarding how it can support eligibility verification across States with the goal of crafting a solution that maximizes accuracy while minimizing administrative burden for applicants and Exchanges. The administrative burden is likely to be exacerbated by Exchange unfamiliarity with communicating with Exchange health consumers and minimal essential coverage program recipients as well as with minimal essential coverage program administrators across states. Successful communication will likely take years to develop. Rather than expend unnecessary resources at the risk of health consumer or patient peril, NPAF suggests HHS contract with the nonprofit community as they are uniquely positioned to maximize accuracy and their familiarity with these parties will minimize administrative burden. By way of example, PAF has a 15 year history in assisting the population to be served by Exchanges in all 50 states. With offices in nine states, it likewise has great relationships with minimal essential coverage programs administrators. NPAF's experience affords it the ability to maximize accuracy in insurance eligibility program verification with minimal administrative burden at the onset of Exchange program operations.

The proposed regulation reveals HHS is considering the feasibility of a central database that employers voluntarily could populate as a potential resource for the verification process. NPAF strongly objects to this approach as it has the potential to threaten health consumer information that should be kept confidential. While we are pleased to note that HHS aspires to include the appropriate privacy and security safeguards necessary to protect the information provided, any problem with the safeguards will place health consumers and not the agency nor the Exchange in jeopardy. In essence, the administrative benefit that the central database provides Exchange employees does not warrant the considerable risk it places on health consumers.

Eligibility Redetermination Process HHS also invites comment on the proposed rule's eligibility redetermination process during a benefit year. The goal of the eligibility redetermination process is to ensure that an individual's eligibility reflects his or her circumstances with respect to eligibility standards while minimizing administrative complexity for enrollees and the Exchange. The process relies primarily on the individual to provide the Exchange with updated information during the benefit year, as opposed to having the Exchange examine electronic data sources and/or contact the individual to determine whether a change has occurred during the plan year.

NPAF Recommendation Regarding Eligibility Redetermination Process While NPAF is in support of this process for most health consumers, special considerations must be provided consumers undergoing periods of illness during a plan year. In such cases, the responsibility individuals have to report any changes to the Exchange with respect to the eligibility standards should be extended for patients undergoing active treatment for a chronic or life-threatening disease.

Health consumer illness status should also be considered in annual eligibility redeterminations. Exchange eligibility redeterminations will occur on an annual basis and are designed to ensure that eligibility determinations remain current and follow the process proposed for the Medicaid program. HHS solicits comments regarding whether the procedures it proposes for redetermination during a benefit year should also satisfy the annual redetermination as well. As the regulation text describes, permitting or requiring a redetermination process that occurs during the coverage year to take the place of the annual redetermination could spread some of the eligibility workload for the Exchange across the year and reduce the number of times when an individual has to review and potentially affirm or update eligibility information. It may also take away from the simplicity offered by a process that occurs at a consistent point in the year for all individuals. NPAF opines that the benefits of this process need not be mutually exclusive. The annual and redetermination that occurs during the benefit year need only occur a week before the annual anniversary. Health consumers should be given notice of when the single redetermination process will occur at the time of application. Ease of administrative burden is particularly important because a study of Massachusetts health exchange experience revealed that a majority of individuals were disenrolled based on a failure to return requests for information rather than no longer meeting eligibility

requirements.⁵ Given this result, the approach that HHS should take in Exchange administration must be designed to benefit health consumers.

Health consumer protections should also be considered in the proposed regulation's text regarding the administration of advance payments of the premium tax credit and cost-sharing reductions. As noted above, health consumers carry the burden of harm associated with the disclosure of personally identifiable information. Unnecessary subsequent submissions of the same data carry with it a greater risk for electronic interception. The proposed rule provides that in the event that an enrollee for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions notifies the Exchange that he or she has changed employers or has terminated coverage in a QHP, the Exchange will transmit the enrollee's name and social security number to HHS, which will transmit it to the Treasury. The potential for harm to the enrollee is lessened if the Exchange transmits the information to both agencies simultaneously.

Finally, the employer participation process in the SHOP should likewise be designed to protect health consumers as well as encourage their participation in Exchanges. The qualified employer should be responsible for not only disseminate information to its employees about the methods for selecting and enrolling in a QHP but for assuring the person to whom this responsibility is delegated is trained to educate employees about the benefits of health insurance coverage and what such coverage means for them. A significant percentage of the people who will enroll in Exchanges will be the working poor, many of whom have not had the benefit of private insurance.

Once again, NPAF thanks you for the opportunity to submit comments. Please feel free to contact me should you have any questions regarding the suggestions included in this comment letter.

Sincerely,



Nancy Davenport-Ennis
Chief Executive Officer



Rene Cabral-Daniels
Executive Vice President of Regulatory Affairs

⁵ "MaxEnroll Minute:Cutting Red Tape to Keep Eligible Families Enrolled in Massachusetts" Maximizing Enrollment for Kids. <http://www.maxenroll.org/resourc/maxenroll-minute-cutting-red-tape-keep-eligible-families-enrolled-massachusetts>