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Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers (CMS-9974-P)

Dear Administrator Berwick:

On behalf of the American Medical Association (AMA) and our physician and student members, I am pleased to offer our comments on the Centers for Medicare and Medicaid Services' (CMS) Notice of Proposed Rulemaking (Proposed Rule) regarding "Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers (CMS-9974-P)." As we have stated in previous correspondence to the U.S. Department of Health and Human Services (HHS) addressing health insurance exchange (Exchange) implementation efforts, we are optimistic that Exchanges have the potential to transform health insurance markets in a way that will benefit both patients and physicians. Exchanges should help to provide health insurance to millions of Americans currently unable to find affordable coverage, and should create choice and competition in health insurance markets. Exchanges should also play a key role in ending many health insurance industry abuses. We applaud your efforts to advance Exchange implementation, and we hope that our comments are helpful in this regard.

Eligibility for advance payments and cost-sharing—§155.305(f-g)

Making health insurance more affordable and accessible for individuals, families, and small business employees through the provision of sliding-scale premium tax credits has been a long-term AMA policy goal. We were pleased that these provisions were included in the Patient Protection and Affordable Care Act (ACA) and are pleased again to see them take another step toward fruition through this Proposed Rule. Tax credits and cost-sharing subsidies should help to provide affordable health care to millions of Americans, which will help to improve the health of these individuals.

Real-time enrollment and coverage information—§155.305(a)(3); §155.315(e)(2); §155.330; and §157.205(f)

One of the biggest challenges facing implementation of Exchanges will be the patient "churn" issue. Millions of patients will cycle through Medicaid, Children's Health Insurance Program (CHIP), and qualified health plans (QHPs) on an annual basis. While the primary focus should be on patients in trying to address the churn issue, how HHS and states address this issue will have a major effect on physicians as well.

The key concern for physicians with respect to the churn issue is the need to have access to real-time, accurate information regarding patient enrollment in a Medicaid plan, CHIP plan or a QHP, and the eligibility, administrative requirements, and cost information for the various procedures and treatments that physicians may prescribe or order. As patients move through various levels/kinds of coverage, their health care options and the cost of such options will change as well. Physicians must have access to accurate, real-time coverage information, or they could end up providing treatments that are not covered by the patient's plan, which would lead to large, unexpected bills for patients that they may not be able to pay. If HHS and states want to ensure adequate provider networks as part of Exchanges, then an effective solution for this issue must be found.

At several points in the Proposed Rule, HHS anticipates changes in plan coverage for patients or disputes and/or questions regarding their eligibility and enrollment. The Proposed Rule attempts to address numerous scenarios, including seasonal workers, eligibility disputes, new employees, and disenrolled patients, among others. These cases all contribute to the patient churn issue that Exchanges will confront. Much of the attention has been focused on income level changes that will lead to eligibility and coverage changes for patients, but the other churn issues raised in the Proposed Rule will be contributing factors as well. For patients and physicians, real-time enrollment and coverage information will be key factors in successfully implementing Exchanges.

The AMA recommends that all QHPs sold in an Exchange be required to provide timely coverage and enrollment information, including precise enrollment and disenrollment dates, for each patient-specific benefit plan and physicians within and outside of the plan's network. This information must be maintained and made available by the health insurance issuer in real-time and batch format. The best option is to require all QHPs offered through an Exchange, including multi-state plans, to provide this information in all of the following methods:

- HIPAA compliant X12 271 eligibility response standard transaction, including the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) operating rules, in response to a HIPAA X12 270 eligibility request;
- Web portal; and
- Other appropriate methods.

This will allow physicians and other health care providers, as well as patients, to be able to access accurate eligibility information prior to and at the time of a patient visit. This will require close coordination among health insurance issuers, Medicaid and CHIP plans, and the Exchanges.

In order to provide patients and physicians with accurate coverage and cost information, QHPs should also be required to implement various ASC X12 health care electronic transaction standards. One option is requiring health insurance issuers to treat the ASC X12 837 Health Care Predetermination:

Professional Transaction (and any of its successors) as mandatory and require them to comply with any operating rules that may be adopted with respect to that transaction or any of its successors. A health insurance issuer's response to such a request by a physician should be returned using the same transmission method as that of the submission, that is, real-time response to real-time response or batch mode response to batch mode response. Such a process would provide valuable coverage and cost information to physicians and patients at the time of a patient visit.

Coordination with Medicaid/CHIP/Basic health plan—§155.305(c-f)

The AMA agrees with the priority that CMS has placed on streamlining the application and eligibility determination and verification processes for Medicaid, CHIP, and QHPs. We support efforts to create a single, streamlined application for individuals to enroll in Medicaid, CHIP, and QHPs. As Exchanges become operational, consumers will likely expect a single access point through which to enroll in health insurance coverage. A streamlined application that is available in paper form and online will help ensure that consumers face a less confusing and complicated application process, especially as many will be unaware of the health insurance options for which they will be eligible.

The AMA also supports allowing states to use an individual's annual income to determine eligibility for advance payment of the premium tax credit and cost-sharing reductions, as well as for Medicaid. This will help to promote coordination between Medicaid and the Exchange and will minimize churn for minor fluctuations in income. By using a single, streamlined application for Medicaid, CHIP and QHPs, and allowing states to use the same income measurement to determine eligibility for coverage in Medicaid as well as for the advance payment of the premium tax credit and cost-sharing reductions, the AMA believes that states will be able to maximize the portion of eligibility determinations that can be completed in a single session.

In-network adequacy for out-of-state dependents—§155.305

We appreciate the opportunity to comment on standards regarding in-network adequacy for out-of-state dependents. With the rate of young adults remaining on their parents' coverage continuing to increase, adequate policies need to be in place to ensure that these dependents, including those who are out-of-state, have access to adequate provider networks. Importantly, parents and guardians need to have the information necessary to determine which plans offered on Exchanges have a sufficient number of primary care and specialty physicians and other health care providers in the state or states in which their dependents reside, so that all individuals covered under the plan will be able to receive all covered services in a timely and geographically accessible basis at the preferred, in-network rate. Such provider network information should also include whether their dependents' physicians and preferred hospitals are in- or out-of-network and whether these physicians and hospitals are still accepting patients insured by the health plan. With this information, parents and guardians will be able to assess whether their current coverage offers network options to ensure that all plan enrollees have access to sufficient in-network providers, or if they need to select another plan that meets their needs.

Redetermination of eligibility on annual basis—§155.335

We support the provisions included in §155.335 that attempt to prevent patients from losing coverage based on the annual redetermination process. It is logical to keep patients enrolled in their current plan if they fail to respond to the redetermination notice and to require them to expressly cancel such

coverage. As stated on previous page, patient churn will be a significant issue for Exchanges to address, and this provision will help to prevent an even bigger churning of the patient population which may not wish to switch from one plan to another or to lose coverage completely. Further, it will help to maintain continuity of care with the current physicians providing their health care.

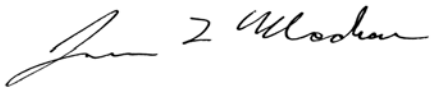
Transition from Pre-existing Condition Insurance Program (PCIP)—§155.345(f)

As the Exchanges become operational in 2014, we believe that high-risk pool plans can be a valuable option in the individual market. Direct, risk-based subsidized plans could be a good choice for patients who were previously covered under a PCIP or state high-risk pool plan. Allowing these plans to be offered through an Exchange could also help to maintain continuity of care for patients.

If the PCIP or state plans are not continued after the Exchanges are operational, then HHS or states should consider mandating a grace period to assist patients transitioning from a high-risk pool plan to another option in the individual market. HHS and the states should also consider allowing patients to maintain their current physicians as they transition to a new plan. With the complicated health care conditions that many of these patients have, uprooting their health care team as they transition from one plan to another could have negative effects on their health.

Thank you for considering our comments. We look forward to continuing to work with CMS and HHS on implementation of additional ACA provisions to expand coverage to uninsured Americans. If you have any questions or would like to discuss our comments further, please contact Margaret Garikes, Director of Federal Affairs, at margaret.garikes@ama-assn.org or (202) 789-7409.

Sincerely,



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