October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9989-P
P.O. Box 8016, Baltimore, MD 21244-8016

Re: CMS–9989–P; Proposed Rules for Establishment of Exchanges and Qualified Health Plans Under the Patient Protection and Affordable Care Act

Dear Sir/Madam:

Thank you for allowing the State of Vermont an opportunity to comment on the proposed HHS regulations related to Exchange Establishment Standards (Part 155) and Health Insurance Issuer Standards Under the Affordable Care Act (Part 156).

We, however, join many other states in voicing our concern about the slow pace at which additional federal guidance is being released. Regulatory speed and clarity will contribute to—and may be critical to--the successful implementation of exchanges in states. In particular, we very much need definition in the essential health benefits in order to proceed with legislation this January. We otherwise would not be in a position to contract with plans in January 2013.

Our comments are organized as follows: We first address three issues of extreme importance to Vermont: (1) states' ability to exclude or fully regulate multi-state plans, (2) the ability of the state to set a higher floor for cost-sharing levels in the Exchange and (3) ensuring the regulation regarding essential community providers provide for the inclusion of a robust network. We then comment of provisions in the order in which they appear in the prosed regulations.

Comments on Critical Issues

Vermont would like to design the Exchange to achieve the state and federal health reform goal of reducing administrative complexity, and thus costs, through a streamlined system, which provides benefits that are easily comparable across plans. For a small state with a small number of lives in the individual and small group markets, competitiveness is not realistic and, therefore, a secondary concern in the design. The unlimited opportunity to enter the individual and small group market does not benefit the state's system and, in fact, creates administrative complexities in benefit design. As Massachusetts learned from its initial offering of at least 25 plans and as all states have learned with the complexities of the Medicare Part D benefit designs, while consumers like some choice, too much choice does not add value to consumers, but rather confuses. In addition, having many many benefit designs creates administrative complexity for health care providers, who then must employ staff to understand and navigate the multiple benefit designs for billing purposes.

We have two comments related to this issue:

1. States should be able to set a higher floor for cost-sharing as long as it complies with one of the federally-defined cost sharing levels.

Section 1321(d) ensures that states have the ability to continue insurance regulation and have flexibility in the design of the Exchange and in the implementation of the ACA. This section says:

> Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

This language establishes the ACA as a "floor" below which states may not fall, but allows states to provider greater protections to consumers in their state. The Vermont General Assembly passed Act 48 of 2010, which establishes the Vermont Health Benefit Exchange and which permits qualified health plans to be offered with cost-sharing requirements beginning with the silver level. This level was chosen, because there was an intent to ensure that Vermont consumers had a minimum level of coverage in qualified health plans and the bronze levels 60% actuarial level was perceived to be inadequate compared to the states current average actuarial level of 87%. The regulations, however, do not appear to conceive of this type of state choice to set a benefits floor above the 60% actuarial value suggested by the ACA. The regulations should be modified to allow states to set a minimum level in this area as in all other areas.

2. Exchanges should be able to fully apply local regulatory standards to multi-state plans.

In Subsection 1334(a) of the ACA, the Director of the Office of Personnel Management is required to enter into contracts health insurance issuers "to offer at least 2 multi-state qualified health plans through each exchange in the state."

State exchanges should not be required to automatically accept multi-state plans unless all standards, which apply to QHPs are applied to the multi-state plans. This is supported by the text of the statute in Section 1324 of the ACA, which provides that multi-state plans and co-op plans must meet the same standards as other insurers.

We are particularly concerned with the proposed language in 155.1010(b), which requires an Exchange to accept multi-state plans without applying the usual certification process that all other QHPs must conform to.

Bifurcating the process allows multi-state plans to avoid state regulation with respect to quality, network adequacy and plan design and insulates these carriers from participation in any state-designed health reform activities. Vermont has only one national carrier in its market now, so it is likely that the OPM plans would be offered by remote carriers, who are unfamiliar with Vermont's market and reform activities. This makes it more likely that their plan designs would undermine, not support, the state's other efforts, in addition to being an invitation to adverse selection.

We are particularly concerned that unregulated plans would undermine the Vermont Blueprint for Health, Vermont's medical home program, upon which the ACA's medical home pilot projects and community health teams were based. Medicaid & Medicare are currently participating in the Blueprint

for Health, which treats all payers identically with respect to their contributions to the community health teams. It would be inconsistent to allow these new plans to avoid participation.

While multi-state plans are deemed certified, that certification should not preclude decertification pursuant to 155.1080(c) on the basis of noncompliance with 155.1000(c)(2): "The exchange determines that making the health plan available is in the interest of the qualified individuals and qualified employers…."

Please work with the Office of Personnel Management to ensure that multi-state plans meet state-specific requirements that are vital to state health reform efforts, in addition to state consumer protection laws.

3. Essential Community Providers

In order to effectively reform health care, newly insured Vermonters must have access to a robust local network of health care providers. This is especially important for Vermonters who are low-income and live in medically underserved communities. Recognizing this, Congress included Section 1311(c)(1)(C) in the Patient Protection and Affordable Care Act. This provision requires health plans sold through state Exchanges to include essential community providers in their networks.

Essential health care providers are crucial to Vermont's health care delivery system because they provide primary and preventative health care services to predominately low-income, medically underserved communities. In the economic downturn, more women and men are turning to these providers for basic health care. For example, while wait times increased for many types of providers after Massachusetts enacted health care reform, it was most problematic for women's health care providers. Wait times for OB/GYN services increased dramatically – to 70 days in the Boston area.

Vermont intends to avoid similar access problems, however, the federal rules should follow Congress' intent to require that all family planning essential community providers are included in the networks of Exchange plans. A "sufficient number" of family planning essential community providers is *all* of them.

It is also important that health plans be required to contract with these providers for all of the covered health services they provide, to ensure continuity and coordination of care – top priorities within the federal health care reform law and for Vermont. The essential benefit rules, when issued, should also clearly include the services provided by family planning essential community providers to ensure that adequate coverage is available.

Comments on Specific Regulations

§155.105 Approval of a State Exchange

The Federal government must approve a state health benefit exchange by January 1, 2013. Please provide additional guidance on the approval process as soon as possible.

An exchange must notify HHS of a "significant change" in its Exchange Plan and receive prior written approval from HHS.

Vermont is designing and building a universal health care system, which expands upon its current health care programs known as Green Mountain Care and in doing so will strive to maximum integration between the Exchange and Medicaid. The state intends to design an Exchange with an infrastructure and information technology system, which could be adapted for ongoing use when the state expands coverage to all Vermonters. It is foreseeable that as Vermont's plans evolve, the state will wish to amend its Exchange Plan as well as the state's Medicaid state plan.

In anticipation that states will need to amend Exchange plans, please clarify the rules to allow the most expeditious process possible for Plan review and approval. It is particularly important for states seeking to fully align exchange and Medicaid programs that exchange and Medicaid plan changes and federal approval be aligned between these two systems as well.

115.110 Entities eligible to carry out Exchange functions

Vermont's Exchange division intends to enter into an intergovernmental agreement with the state department of insurance for certain exchange functions for which the department is ideally suited by virtue of its expertise in rate-setting and issuer oversight. In the interest of clarity, the state would like the rules to specify that departments of insurance are entities eligible to carry out Exchange functions, as are State Medicaid agencies.

Subdivision (c) outlines requirements for an Exchange governing board when the exchange is an independent State agency or non-profit entity.

Vermont has housed its Exchange in a division of the Department of Vermont Health Access, which also operates as the state's Medicaid managed care entity. Vermont interprets this section to mean that a dedicated division within the existing state department is not required to establish a *governing* board meeting this criteria and that an advisory board may be used to seek information and advice on program policy and operations. Requiring a governing board for an existing state agency would be inconsistent with the current state structure. Please clarify the rules to indicate that governing boards are appropriate for stand-alone Exchange agencies or non-profits, but not a typical government department.

While the regulation does not say otherwise, we wish to comment that we intend to apply our current state standards of financial disclosure and conflict of interest to the operation of our exchange.

155.130 Stakeholder consultation

The ACA does not require consultation with large employers or brokers but the regulations do. Vermont's health care reform law does not require consultation with these groups and the state seeks flexibility to consult consistent with ACA and Vermont statutory requirements. It would be appropriate to consult with large employers once the Exchange is planning for and open to these employers. It is not

appropriate to apply the comments of large employers to an Exchange which is not available to them prior to the planning process for their inclusion.

§155.160(b) Exchange Sustainability

The proposed regulation says that (1) a state may fund its exchange by assessing participating issuers and (2) may otherwise generate funding. Vermont currently has an insurer assessment. Under a strict reading of the regulations as currently written, a court could prohibit the application of these funds for Exchange purposes. Under some circumstances, it may be advisable to assess all health insurance issuers. We ask that this provisions be clarified to allow the use of an assessment on all insurers.

§155.200 Functions of an Exchange

We intend to comment in detail on the proposed regulations but would like to take this opportunity to express our concern about federal requirements for carrying out, enforcing and reporting eligibility, exemption determinations, tax exemptions and advanced eligibility for exemptions. These intergovernmental activities are fraught with opportunities for excessive administrative burden (at both the federal and state levels) and the possibility that these requirements will slow and even impair successful exchange operations. We therefore urge that wherever possible these requirements be simplified and allowed to operate where possible using retrospective reconciliation.

155.210 Navigator program standards

The state does not believe it is appropriate to allow issuers to pay entities who serve as navigators for services related to coverage outside the exchange. While it may be appropriate to broker activities in a traditional insurance market, the possibility of steering consumers to a plan outside of the Exchange poses a significant threat for enrollment in Exchange plans. Allowing issuers to pay navigators differently for services outside of the Exchange creates a conflict of interest for the navigator and could create a financial incentive for the navigator, which is not in the consumers best interest. The regulations should apply consistent rules to navigators in order to avoid conflicts of interest.

155.230 Notices

The state seeks clarification that the requirement that notices be “in writing” includes notices by email.

It would be unduly burdensome to require federal approval for all changes in the form of the many notices Exchanges would be required to issue. This requirement is excessive, especially since some of the notices will need to be tailored to state-specific Exchange designs. We propose narrowing or eliminating the requirement for federal approval of notices.

155.240 Payment of Premiums

Vermont operates a program (Catamount Health) wherein the State aggregates premium from participating individuals, adds a subsidy and forwards both in a bulk payment to a participating carriers. While this approach is consistent with one of the three premium collection methods described in HHS’s

comments on the proposed rule, HHS has also stated an intention to require, as an alternative, direct payment to the issuer. We believe that allowing alternative payment methods add to cost and invite confusion. We request the flexibility to be allowed to require premium aggregation as the only permitted method of payment.

§155.400 Enrollment of Qualified Individuals in to QHPs

Subdivision (a)(2) requires the Exchange to transmit information necessary to enable the QHP issuer to enroll the applicant. This does not fully accord with §155.205(b)(6) where the exchange website must have the capability to allow enrollment. Please clarify whether these are intended as enrollment alternatives.

§155.410 Initial and annual open enrollment periods

The rule proposes a set, annual enrollment period in the fall before the next calendar year. The rule should give states flexibility to establish a rolling open enrollment periods and to tailor the enrollment periods to the needs of Vermonters.

This is especially true of the first few years of a new program. For example, the rule proposes an annual open enrollment period from October 1st to December 7th in 2014 for the 2015 calendar year. Vermont's experience in introducing a new state-subsidized insurance product, Catamount Health, shows that consumers may be slow to take up a new product. This was also the case in Maine with the Dirigo product. A rolling enrollment period, at least during the first year or two, would provide for more time to enroll individuals and would ensure that enrollment into the Exchange was robust.

While Vermont agrees that an expansive initial open enrollment period will help attract enrollees—a goal we share—we are concerned that issuers will not be able to compile realistic first year rates; we suggest an opportunity for interim rate adjustments in the first year pursuant to state approval.

The rule should clarify interactions with COBRA, such as whether an individual is required to elect COBRA coverage. Vermont recommends that an individual be allowed to drop COBRA coverage and enter the Exchange. In addition, the qualifying event categories should be broadly defined in order to avoid individuals being locked out of coverage because they are unable to enroll in the Exchange. For example, an individual who loses employer-sponsored insurance because an employer drops coverage or because an individual's hours are reduced and s/he is no longer eligible should be allowed to enter the Exchange or to change from a plan offered by an employer in the exchange to an individual product. States should be allowed a discretionary category in the qualifying events, in case of an extraordinary situation. Lastly, it should be clear that allowing enrollment could be a reasonable accommodation to certain types of disabilities and should be allowable.

155.705 Functions of a SHOP Exchange

This provision requires a qualified employer to select a level of coverage within which an employee can choose any coverage offered in the exchange. Subdivision (b)(3) provides that a SHOP Exchange may allow employers to make available "one or more" plans using a method other than the one established

in subdivision (b)(2). The rules should be clarified to allow these options as alternatives in a states discretion.

Please also clarify that subdivisions (b)(2) and (b)(3) allow an exchange to permit an employee to pick a level of coverage "as described" in §1302(d)(1) but to limit the available levels of coverage to less than four. As noted above, Vermont law presently precludes the offering of "Bronze" plans.

Lastly, the state received feedback in focus groups that many Vermonters had a negative reaction to the names of the levels (bronze, silver, gold, platinum). The focus group participants perceived a bias based on these names. Please consider allowing states to rename the levels of coverage available through the Exchange.

155.715 Eligibility determination

We believe that requiring a SHOP Exchange to deny eligibility to an individual or employer who fails to provide satisfactory information within thirty days is too restrictive and unnecessarily limits entry to the Exchange. Please consider modifying the time limit from 30 to 60 days.

155.1040 Transparency

This rule requires Exchanges to collect and regulate information relating to coverage transparency. The rule should be modified to allow Exchanges to contract this function to another entity or to allow interdepartmental agreements, so this analysis could be part of the insurance rate and forms review by the insurance department. There may be ways to streamline this regulatory function and the rule should not be so restrictive.

156.245 Treatment of direct primary care medical homes

This provision states that coverage provided through a primary care medical home must comply with requirements established by HHS. These requirements must be as flexible as possible to avoid unnecessary interference with established medical home programs in the states. Vermont has been a leader in creating medical homes with associated community care teams, called the Blueprint for Health. We are in the process of a statewide roll-out of this program, which is scheduled for completion in 2013. Any new requirements by HHS must recognize existing state programs and not undermine medical home programs which are successfully being implemented.

156.275 Accreditation of QHP issuers

Vermont asks that the rule be clarified so that the affirmative requirements of 156.275 clearly not preclude a state from imposing its own additional accreditation requirements for QHPs consistent with present or future state standard for issuance of health insurance coverage. This is consistent with the preemption provisions in the ACA, which call for it to be interpreted as minimum standards.

156.280 Segregation of funds for abortion services

Vermont asks that with respect to abortion services that states that support such services as a matter of public policy be permitted reasonable flexibility to provide such services without hindrance or penalty resulting from federal rules.

Lastly, Vermont would like to support the following overarching themes submitted by the National Association of Medicaid Directors (page 2 of their submission):

- Timely, comprehensive information is essential or meeting deadlines
- Program integrity rules need clarification and alignment
- Federal agency coordination is vital for consistent, timely guidance to states

Thank you again for the opportunity to comment. We look forward to working with you.

Sincerely,

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