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Centers for Medicare & Medicaid Services,
Department of Health and Human Services
Attention: OCIIO-9989-NC
7500 Security Boulevard
Baltimore, MD 21244-1850.

Submitted Electronically: <http://regulations.gov>

RE: OCIIO-9989-NC (Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act)

To Whom It May Concern:

The Medicare Rights Center is a national non-profit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs and public policy initiatives. We thank you for the opportunity to provide comments on the planning and establishment of State-Level Exchanges.

The Affordable Care Act (ACA) expands Medicaid eligibility to many individuals 64 and younger with incomes up to 138 percent of the federal poverty level (FPL), and creates new rules and standards for determining Medicaid eligibility—for instance, requiring states to use “modified adjusted gross income” (“MAGI”) and eliminating the asset test. But the ACA specifically excludes from this new eligibility standard the Medicare eligible population: people age 65 and over and people with disabilities under 65, including individuals for whom Medicaid is paying Medicare cost-sharing amounts (i.e., those who are “dual-eligible” or enrolled in Medicare Savings Programs (MSPs)). These individuals are now being referred to as “non-MAGIs.”

States must ensure that non-MAGIs are included, to the maximum extent possible, in new Medicaid- and Exchange-related enrollment systems and subject to streamlined and simplified income and asset budgeting rules (so long as eligibility is not compromised). Such inclusion becomes especially relevant if states enact policies and implement systems to encourage “no wrong door enrollment” for MAGIs, as anticipated by provisions of the ACA that require

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applicants for both Exchange and Medicaid coverage to be considered for all possible insurance programs. As a result of these provisions, a MAGI individual who applies for Medicaid but whose income is found to be too high would then be considered for tax credits related to purchase of a QHP, and vice versa. If newer more modern and effective application and recertification processes are put in place for MAGIs, the same pathways should be available for non-MAGIs through the Exchange and Medicaid related enrollment systems and third party data matching.

Medicare Rights' comments are focused on the non-MAGI population, and are geared toward assuring that this population will be part of new modernized systems that many states may develop as a result of the ACA for the MAGI population, specifically, innovative systems that would progress the goal of seamless enrollment. Such enrollment systems for Medicaid, MSPs, and the Low-Income subsidy program (LIS), will help to assure that people with Medicare who have limited incomes will have access to benefits that they deserve and could help strengthen their financial outlook.

Should you have any questions or require additional information, please contact Ilene Stein, Policy Counsel, at 202-637-0961, ext. 5, or istein@medicarerights.org.

Comments

A. State Exchange Planning and Establishment Grants

4. What kinds of factors are likely to affect States' resource needs related to establishing Exchanges?

b. To what extent do States have existing resources that could be leveraged as a starting point for Exchange operations (e.g., existing information technology (IT) systems, toll-free hotlines, Web sites, business processes, etc.)?

Establishing enrollment systems related to Exchanges and other programs, including Medicaid, is an opportunity for states to update their IT systems. In particular, it is an opportunity to make these systems more compatible across different state-based programs (encouraging express-lane eligibility), as well as with other states' systems and the federal government's systems, which will allow for more efficient transfer of data. Some states are planning to use old data systems as the basis for their Exchange. To encourage modernization of data systems, the federal government should offer technical support and financial aid to encourage states to update their systems.

Many underlying enrollment systems are inadequate. The limitations of current data systems are demonstrated by problems with the data exchanges occurring between the federal government and the states to facilitate enrollment into MSPs and Part A and B Buy-In. The state and federal systems are not compatible, and data cannot be properly exchanged to trigger enrollment into a benefit unless the data files match. If the data files don't match, the file is sent back and forth between the state and federal system until the discrepancy is resolved. This can take months, and it is often difficult to determine which data element is causing the problem. In the meantime,

individuals go without much needed benefits and put strains on state-based and emergency health systems.¹

These types of issues must be addressed for both the MAGI and non-MAGI populations. Many advocates are hopeful that new enrollment systems in the Exchange for the MAGI population will help to eliminate some of these technical issues, but it is imperative that these issues are eliminated for non-MAGIs as well and that states are encouraged, including through financial incentives, to modernize data systems overall. We believe for this reason states should establish “no wrong door enrollment,” where people apply for benefits at a single entry point using a single multi-purpose application form. As previously stated, this means that people do not apply for a QHP through the Exchange, Medicaid, or other programs separately, but apply for all at the same time using the same application or “portal.” There now exists an opportunity to create a similar “no wrong door enrollment” policy for low-income people with Medicare who are eligible for Medicaid, MSPs, and LIS. This type of system update could occur regardless of enrollment formulas and eligibility criteria; such changes focus on the underlying technology and format of a system itself.

Given many states’ current fiscal status, it is important that the federal government provide sufficient resources, including financial aid, to assist states in updating their current enrollment systems. Even if states desire to overhaul their data systems, many states will be unable to do so without additional financial, programmatic, and technical assistance.

5. What kinds of questions are States likely to receive during the initial planning and start-up phase of establishing Exchanges? How can HHS provide technical assistance, and in what forms, in helping States to answer these questions?

The Department of Health and Human Services (HHS) has the opportunity to guide states to integrate non-MAGIs in enrollment systems for MAGIs by equipping states with the proper tools to do so. HHS must provide programmatic support and quickly disseminate best practices and models on the development of enrollment policies and IT systems to states. Sharing successful concepts, whether it is enrollment rules or IT systems, will also lead to better compatibility among systems between states as well as between states and the federal government. One concrete action HHS can take, is to provide software and other programming that would assist states in creating new compatible and modern data systems. Software or programs should be created in a manner that allows states the ability to modify the tools to best fit their needs. Also, if HHS establishes Exchanges because states do not establish their own, the federally developed Exchanges can serve as an important model for states as well. HHS should disseminate its own Exchange plans to states and conduct the establishment of Exchanges in a transparent manner.

In addition, as mentioned previously, states may require financial support to modernize underlying enrollment systems, many of which are outdated and potentially ill-equipped to support the type of automatic enrollment envisioned by the drafters of the ACA.

¹ Goggin-Callahan, D., *Warning Signs: Preliminary Report Highlights Problems with State Implementation of MIPPA Low-Income Reforms*, Medicare Rights Center, February 2010. Available at www.medicarerights.org/pdf/Warning-Signs-MIPPA.pdf, accessed October 1, 2010.

C. State Exchange Operations

1. What are some of the major considerations for States in planning for and establishing Exchanges?

States need resources not only to examine what is necessary to have an Exchange and related enrollment systems up and running in 2014, but also to learn how to build systems that can evolve over time and be adapted to allow states to simplify enrollment into other state-based programs or experiment with different enrollment practices generally. Enrollment systems should be built in a manner that leaves room for further innovation.

As previously stated, as the Exchanges develop, it is important to encourage states to develop systems that allow “no wrong door” access to benefits. There is great opportunity for improvements to existing systems made possible by the ACA and encouraged by the language of the law. For MAGIs, the ACA allows determinations and processing of different eligibility requirements and formulas to occur behind the scenes, which would help create a seamless application process for consumers. This means that when consumers provide information about their incomes, the system should be equipped to make determinations about eligibility for various premium subsidies or Medicaid, without the consumer needing to make an affirmative choice to apply for a particular program or set of tax credits. The ACA anticipates seamlessness by requiring states to develop online application and recertification tools for the MAGI population. Non-MAGIs stand to benefit from these practices as well. As states evaluate and potentially rebuild existing systems, it would serve both state agencies and the non-MAGI population to include all enrollment, recertification, and insurance management functions into the new or rebuilt systems, for non-MAGIs as well as MAGIs. Such inclusion would eliminate many of the problems we see today with outdated, patchwork systems. These new systems will help people overcome some of the technical problems, such as data sharing, which create hurdles to enrollment. Such is the promise for MAGIs and we hope for non-MAGIs as well.

In addition, HHS should encourage states to examine eligibility criteria for the non-MAGI population to determine if changes could be made to better incorporate this population into new enrollment systems, streamlining enrollment for all. For example, in 2008, New York eliminated the asset test for MSPs, not only expanding the pool of individuals eligible for the benefit, but also allowing for more effective enrollment practices and for ease in future implementation of laws meant to streamline enrollment such as the Medicare Improvements for Patients and Providers Act (MIPPA).² HHS should disseminate enrollment practices that serve as models to other states.

Allowing non-MAGIs to enroll in low-income programs through the enrollment systems used for the Exchange and Medicaid or a similar system (“no wrong door enrollment”) would also help to smooth the transition from QHPs and expanded Medicaid to Medicare, when people turn 65 or become eligible owing to disability. The rules governing the transition from a QHP with a premium subsidy or expanded Medicaid to Medicare (*e.g.*, what notice must occur, how and if

² Dershowitz, S., *Local Promise: Maximizing Enrollment into Low-Income Medicare Programs through State-Based Consumer Advocacy*, Medicare Rights Center, July 2010. Available at www.medicarerights.org/pdf/Local-Promise.pdf accessed October 1, 2010.

coverage will end, etc.) are not yet clear. It is uncertain which entity would be in charge of the calculation and enrollment process for non-MAGIs within states. Further, individuals who had been using the Exchange and then become Medicare-eligible would need to familiarize themselves with new, more complicated systems, which could lead to disenrollment and low enrollment in programs that could help assuage the cost of Medicare and ease the financial burden of transitioning from more heavily subsidized coverage to Medicare. This is especially of concern for low-income individuals—for example, those with income between 100 and 138 percent of FPL, who will be covered under expanded Medicaid as MAGIs.

2. For which aspects of Exchange operations or Exchange standards would uniformity be preferable? For which aspects of Exchange operations or Exchange standards is State flexibility likely to be particularly important?

While there needs to be sufficient flexibility to account for different state structures and cultures, it is important that data systems be properly compatible with systems in the federal government. For example, there should be standard fields in enrollment forms and other online systems to prevent potential data exchange issues. Alternatively, the federal government should work with states to establish a method for troubleshooting difficulties that arise as a result of data transfers and that prevent proper and timely enrollment.

In addition, Exchange and Medicaid enrollment systems and processes must be transparent. Until now, understanding the details of how enrollment works has been difficult. The smallest technical details often become very relevant in determining why an enrollment did or did not occur. Transparency in process will improve advocates' and states' ability to troubleshoot problems and also to advocate for simple improvements in policies and systems that could make an important difference in the timeliness of an enrollment or the timeline it takes to resolve issues.

3. What kinds of systems are States likely to need to enable important Exchange operational functions (e.g., eligibility determination, plan qualification, data reporting, payment flows, etc.), to ensure adequate accounting and tracking of spending, provide transparency to Exchange functions, and facilitate financial audits?

What are the relative costs and considerations associated with building Exchange operational, financial, and/or IT systems off of existing systems, versus building new stand-alone Exchange IT systems?

Please see previous comment for section (A)(4)(b).

G. Enrollment and Eligibility

2. What are some of the key considerations associated with conducting online enrollment?

Please see comment below for section (G)(6).

3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

Please see previous comment for section (C)(1).

6. What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment?

The ACA provides for third-party verification (*i.e.*, verification by the IRS) of data provided by MAGI applicants for the Exchange. This is not the case for the non-MAGI population, and presents a significant hurdle in streamlining the application and recertification process for this population. While in many cases the MAGI population will not need to provide supporting documentation that is now required to verify information provided on applications, the non-MAGI population will still be required to do so. These documentation requirements prevent automation of enrollment. States may be able to verify some data (for example, through information provided on state tax returns). If such information can be verified by states, then documentation requirements can be eliminated.

H. Outreach

2. What resources are needed for Navigator programs? To what extent do States currently have programs in place that can be adapted to serve as patient Navigators?

With the opportunities afforded by the ACA come significant challenges and uncertainties about how we will make sure everyone will get what they need. Programs exist now to help people with Medicare navigate health systems. State Health Insurance Programs, Area Agencies on Aging, Title IIIB legal service providers, Ombudsman programs and Aging and Disability Resource Centers are just some of the important resources that currently exist. New navigator programs should build on and maintain tight relationships with these entities to ensure that Medicare consumers do not fall through the cracks.

Also, the aforementioned Medicare outreach programs as well as other existing programs could serve as models for the development of Navigator programs. For example, New York has a history of supporting consumer assistance in public insurance enrollment through community based approaches, leveraging partnerships with consumer service organizations. Federal regulations should be designed so that states build on the success of existing programs (if such programs exist), aiming to make assistance and navigation as globally accessible as possible, at every step of the process.

To adequately provide for consumer assistance and navigation, states must fund an independent consumer assistance program made up of community-based organizations statewide that already have historical knowledge and expertise in assisting the diverse people in the communities in which they work. In addition, states must support education and outreach to underserved

constituencies through multiple media efforts (print, social networking, radio, etc.), community- and faith-based organizations, schools and other venues.

HHS should examine local innovative practices that have helped to increase enrollment into programs and educate consumers about benefits options. For instance, Medicare Rights through the New York City Deputization Project, with support from the Human Resources Administration (HRA), New York City's Department of Social Services (DSS, or Medicaid) office, trains professionals at community-based organizations (CBOs) on how to help their clients complete low-income program applications; since its inception, thousands of new MSP and LIS applications for seniors and people with disabilities have been processed throughout New York City.³

J. Consumer Experience

2. What are some best practices in conveying information to consumers relating to health insurance, plan comparisons, and eligibility for premium tax credits, or eligibility for other public health insurance programs (e.g., Medicaid)?

To be most effective, efforts to convey accurate and individualized information to consumers should take many different forms. Enrollment activity should be preceded by a highly visible and sustained media campaign—including television, radio, print, and social media—to raise the public's awareness of the Exchanges.

In-person opportunities for consumers to receive individualized assistance and have their questions answered is the method most useful with hard-to-reach consumers. There are several models for this approach including the State Health Insurance Assistance Program (SHIP), which offers free one-on-one counseling to individuals with Medicare and their families through in-person and telephone counseling, as well as public education presentations, interactions with public service agencies, and counseling services offered by non-profit organizations.

Some of the more successful outreach efforts utilized during the launch of the Part D prescription drug benefit were the web-based enrollment options, the toll-free hotline, and the enrollment information fairs at houses of worship, congressional town hall meetings, grocery stores, and other places where consumers congregate. Some states also utilized mobile units that traveled between cities and neighborhoods to reach people where they lived. Additionally, respected local organizations and coalitions have provided support to individuals in diverse populations regarding the Medicare Part D and other Medicare programs.⁴ Coalitions that include organizations and state agencies, such as The New York State Medicare Savings Coalition, led by Medicare Rights, have offered guidance and technical support to local teams assisting Medicare beneficiaries.⁵ Other examples include New York MCCAP and the Coalition of

³ Medicare Rights Center's New York City Deputization Project. Description available at www.medicarerights.org/about-mrc/services_professionals.php, accessed on October 1, 2010.

⁴ Dershowitz, *Local Promise* ; Summer L, O'Brien E, Nemore P and Hsiao K. Medicare Part D: State and Local Efforts to Assist Vulnerable Beneficiaries. The Commonwealth Fund. April 2008. Available at: <http://www.hapnetwork.org/assets/pdfs/commonwealth-lis-outreach.pdf> last accessed October 1, 2010.

⁵ *Id.*

Wisconsin Aging Groups. MCCAP, a network of 25 organizations, will serve as the primary navigational support resource for MAGIs and non-MAGIs, assisting consumers, communities, and social service organizations in navigating New York's health care systems and services. The Coalition of Wisconsin Aging Groups is a consumer-led coalition that helps promote intergenerational understanding and leadership development, public education, legal and legislative advocacy, and public policy development.

3. What are best practices in implementing consumer protections and standards?

Consumers are already experiencing increased protections from the ACA, and in 2014 when the Exchanges are launched, the final major reforms will be in effect. From that point on, consumers cannot be denied coverage due to pre-existing conditions, premium rating rules will be applied, out of pocket expenses will be capped, and insurers will have to offer at least a minimum set of essential benefits in each policy.

Guaranteeing full and adequate implementation of these and other consumer protections requires comprehensive public education and information. The more people understand their new rights under the ACA, the more people become deputized to help their family, friends, and neighbors interact with the new health care system. Plain language educational materials should answer common questions, supply timely information on enrollment problems that arise, provide clear guidance (supplemented by telephone and in-person assistance) for people who believe they qualify for an exception to the coverage requirement, and provide information on the appeal process for tax credit eligibility and amounts.

The start-up of the Massachusetts Exchange may serve as a useful model for public education efforts conducted beyond traditional health care settings (such as sports venues) and for a rapid implementation of new policies. In addition, the implementation of the Medicare Part D benefit may serve as a model. CMS staff and Medicare advocates should be consulted on best practices and lessons learned from the introduction and ongoing implementation of the drug benefit, particularly in avoiding some of the implementation problems that occurred in its first year.

K. Employer Participation

4. What other issues are there of interest to employers

The Exchange must offer assistance to employers purchasing coverage for employees through the Exchange to help properly coordinate care for Medicare-eligible employees. Currently, insurance offered by small employers pays secondary to Medicare, often acting as supplemental insurance that covers out-of-pocket costs not covered by Medicare. Will QHPs provide this type of supplemental coverage in a manner that will make it economical for small employers and employees? How will QHPs' coverage coordinate with Medicare coverage, if at all? HHS should consider releasing regulations and guidance that clarifies the relationship between coverage through a QHP offered by an employer and Medicare.