October 4, 2010

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Attention: **OCIIO–9989–NC, Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act**

Dear Secretary Sebelius:

The undersigned organizations submit the following in response to a request for comments regarding the Exchange-related provisions of the Patient Protection and Affordable Care Act (hereinafter the Affordable Care Act). We commend the Department's early work in implementing the American Health Benefits Exchanges (hereinafter Exchanges). These Exchanges, created under Sections 1311 and 1321 of the Affordable Care Act, provide enormous opportunity to bring new competition and consumer protections into the insurance market, and, if implemented effectively, can improve access to health care. In general, as the Department takes steps to implement the Exchanges, we urge that the Department in particular pay heed to the needs of low-income individuals who depend on safety net providers and programs and who may be most at risk as we transition into this new system.

We also urge the Department to take into account the ways in which Section 1303, which creates "special rules" for qualified health plans (QHPs) that include coverage of abortion, interacts with other Exchange-related requirements. Currently, abortion is a covered service in the majority of private health insurance plans, and Congress' intent in Section 1303 was to preserve widespread availability of coverage for abortion care both within and outside Exchanges. Congress thoroughly debated including coverage for abortion in its consideration of the Affordable Care Act, and ultimately rejected proposals to ban such coverage in the new health care system, instead allowing issuers of QHPs to determine whether or not to include abortion coverage as part of its plans. We urge the Department, in implementing Exchange-related provisions of the Affordable Care Act, to honor Congressional intent and ensure that women can continue to obtain comprehensive health insurance that meets the full range of their reproductive health needs.

The following provide specific responses to questions posed in the Department's request for comment:

IMPLEMENTATION TIMEFRAMES AND CONSIDERATIONS

The Department has asked, in questions B.2 and B.4, what guidance is needed and what provisions require additional clarification for states, plans, and consumers to begin the process of planning for Exchange implementation and participation. In order to ensure that relevant actors have the information needed to maintain insurance coverage of

abortion while still complying with the requirements of the Affordable Care Act, we urge the Department to promulgate implementing regulations for Section 1303, which establishes "special rules" for the coverage of abortion services in QHPs, as soon as practicable. We are concerned that any delays in Section 1303 rulemaking will place additional burdens on insurance plans and will decrease the likelihood that plans will provide coverage of abortion, in violation of Congress' intent to preserve the coverage individuals currently have.

STATE EXCHANGE OPERATIONS

The Department has requested information to consider as it develops standards for states to create health insurance Exchanges. Because Section 1303 establishes "special rules" for the coverage of abortion services in QHPs, the Department must take into account the need to preserve Congressional intent with respect to abortion coverage in the standards and guidance it provides to states governing Exchange operations. To that end, we urge the Department to consider the following:

Standards for Non-Profit Exchanges

Pursuant to Section 1311(d)(1), a state must decide whether an existing state agency, a new state agency, or a non-profit entity established by the state will operate the Exchange. The Department should make clear that, if a state elects to establish a non-profit entity to operate its Exchange, the non-profit entity must not be permitted to exclude plans on the basis of the coverage the plan provides if it otherwise satisfies the benefit requirements of a QHP as defined under Sections 1302(b) and 1303 and applicable state law. In particular, we urge the Department to ensure that, absent state law as permitted under Section 1303(a), a non-profit Exchange cannot prohibit plans that include coverage of abortion from participation.

Regional or Interstate Exchanges

Under Section 1311(f)(1)(B), the Secretary is required to approve any regional or interstate Exchange before it can operate in more than one state. We urge the Secretary to establish clear standards for the approval or disapproval of regional or interstate Exchanges. In particular, we urge the Secretary to establish a clear standard that the Department will not approve a regional or interstate Exchange that fails to include at least one plan that provides coverage of abortion services unless each of the states participating in the Exchange have enacted laws to prohibit all such coverage under Section 1303(a).

QUALIFIED HEALTH PLANS

Ensuring a Sufficient Choice of Providers / Essential Community Providers

As noted in the request for comment, Section 1311(c)(1)(C) of the Affordable Care Act establishes a critical protection to make sure newly insured patients can access the health care they need. In order to ensure that patients have access to the providers in their communities, Congress required under Section 1311(c)(1)(C) of the Affordable Care Act that health plans participating in state-based Exchanges must contract with essential community providers (ECPs), which includes women's health centers, HIV/AIDS clinics,

community health centers, and public hospitals. This protection will help millions of women and their families receive the primary and preventive care they need, and it is fundamental to resolving the overwhelming provider access issues that can so easily come with expanding coverage to 32 million Americans.

The ECP protection in the Affordable Care Act will go a long way towards guaranteeing not only coverage, but access to care for millions of Americans. Unfortunately, many health insurance companies fail to contract with ECPs, leaving Americans with an insurance card but without access to the doctors, nurses, and other health professionals they need.

- In Massachusetts, as a result of expanding coverage without putting strong access protections in place, there are tremendous shortages of primary care providers, especially those that focus on women's health care. After universal coverage was enacted in MA, waits for OB/GYN services increased (there is now an average 70 day wait in Boston).[1]

- Without the ECP protection, costs would have shifted to patients. A recent Health Care for America Now! (HCAN) report highlighted the stories of consumers facing inadequate provider networks. As the report shows, when a patient is forced to go "out-of-network" for health care, they end up paying higher out-of-pocket costs—in some cases, the majority of the cost of the visit.[2]

In order for the provision to have its intended impact, it is imperative that the Department implement the ECP protection in a meaningful and robust way so that patients are guaranteed access to the providers they trust in their communities. Congress identified a number of providers—340B and "340B look-alike" providers— with whom Exchange-participating health plans must contract, and the HHS rulemaking should reiterate and emphasize that requirement. This group of providers represents a broad swath of the community-based providers in our country, including public hospitals, community health centers, and family planning clinics.

In fact, implementing regulations should make certain that all the ECPs Congress intended to be protected are protected by the provision, including family planning clinics and women's health centers. Given the unique health care access needs of women, it is especially important that HHS emphasize the importance of requiring Exchange-participating health plans to contract with family planning clinics and women's health centers.

In addition, to achieve the true intent of the provision—which was to ensure numerous access points—HHS should require that health plans contract with essential community providers for all of the essential health benefits they provide. In addition to providing

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[1] Merritt Hawkins & Associates, 2009 Survey of Physician Appointment Wait Times 9 (2009), *available at* http://www.merritthawkins.com/pdf/mha2009waittimesurvey.pdf.

[2] Health Care for America Now!, Health Insurance Company Abuses: How the Relentless Drive for Profit Endangers Americans 4 (2009), *available at* http://hcfan.3cdn.net/48b73f19dac6bc9fa7_vzm6iijoh.pdf.

more efficient and patient-centered care, this requirement would also support better continuity and coordination of health care—top tenets of the Affordable Care Act.

It is also important that protections are put in place to ensure that essential community providers are not discriminated against in health plans' reimbursement negotiations. In order to make sure that the ECP provision supports vigorous community-based health care delivery networks, the Secretary should put protections in place to ensure that ECPs are adequately reimbursed for the health care they provide.

Finally, to make certain that health plans meet the requirements of ECP provision and are including all relevant ECPs in network, HHS should put enforcement mechanisms in place. For instance, rulemaking should contemplate a process for the state-based health insurance Exchanges to monitor plans' compliance with Section 1311(c)(1)(C).

Ensuring a Sufficient Mix of Qualified Health Plans

The Department, in its request for comments on QHPs, has asked for information on factors necessary to ensure a sufficient mix of QHPs in the Exchange. Selecting and sustaining a sufficient mix of QHPs should–absent a state law prohibiting such coverage–require inclusion of at least one QHP that offers coverage for abortion services described in Sections 1303(b)(1)(B)(i) and 1303(b)(1)(B)(ii). This is necessary to guarantee that women participating in an Exchange are provided with comprehensive coverage options that meet their medical needs, and to ensure that women are able to receive the full benefit of the new law as passed, which specifically allows for coverage of abortion in the new health care system (see Section 1303(b), et. seq.). Absent state law prohibiting abortion coverage in that state's Exchange, we urge the Department in its implementing regulations to define a sufficient mix of QHPs as including at least one plan that offers coverage of abortion services.

Network Adequacy

Section 1311(d)(4) requires Exchanges to employ certification, recertification and decertification of health plans as QHPs based on criteria developed by the Secretary. Among the essential criteria are ensuring a sufficient choice of providers to meet the health needs of the enrollees and providing sufficient information to enrollees and prospective enrollees about the availability of providers and services.

The criteria developed by the Secretary to determine whether a QHP has a sufficient range of providers should take into consideration the fact that many religiously-controlled hospitals and clinics may not provide all of the covered services. In addition, individual providers may refuse to offer covered services. These restrictions may limit access to comprehensive reproductive health services and information, as well as end of life care and information about treatment options. An adequate network must include providers that offer all covered services.

Moreover, in the event that an enrollee is not able to access the reproductive health services that she needs within the network, in particular due to provider religious or moral objections, the QHP must be required to allow the woman to access services out of

network without penalty, including in the case of emergencies.

Information

The criteria developed by the Secretary for Exchanges to certify health plans as QHPs should also ensure, as required by law, that information and materials are easily accessible to individuals who are of low literacy and/or limited English proficiency (LEP). QHPs should provide meaningful access to LEP individuals through translation of materials into threshold languages, as well as providing competent oral interpreters for all LEP applicants, potential applicants and enrollees to ensure that LEP individuals understand the nature and scope of the services, any possible appeal process, enrollment/disenrollment processes and any other pertinent information about the QHP and the services provided. Linguistic competency including translation services and interpreter services must also be required in web portals, as discussed below, outreach materials, and marketing materials.

Multi-State Plans

The Department has requested information regarding any special factors that must be taken into account in establishing standards for the participation of multi-state plans in Exchanges. We urge the Department to harmonize provisions in the Act pertaining to multi-state QHPs and to abortion coverage and to clarify that multi-state plans are allowed to cover abortion, even if that would result in a lack of uniformity across states.

In Section 1303 of the Affordable Care Act, providing "special rules" for abortion, the Act explicitly reiterates states' ability to pass laws prohibiting abortion coverage in their Exchanges and provides generally that the Act does not preempt state laws prohibiting or requiring abortion coverage. Problematically, however, Section 1334(c)(1)(A) requires that multi-state plans offer "a benefits package that is uniform in each State." Reading these provisions together, the Act could be wrongly interpreted to mean that if a multi-state plan is offered in a state with a law prohibiting coverage of abortion, that multi-state plan could not offer abortion in *any* participating state, because then benefits would not be "uniform in each state."

Such a result would conflict with Section 1303(b)(1)(A)(ii), which allows the issuer of a QHP to determine whether or not that plan provides coverage of abortion services. It also conflicts with Section 1334(a)(6), which, in requiring that there be at least one multi-state plan that does not provide coverage of abortion services, implies that other multi-state plans may provide abortion coverage.

The provision guaranteeing that one multi-state plan will not cover abortion was part of a legislative compromise on abortion and was intended to guarantee that individuals participating in state Exchanges would be able to choose a plan that does not cover abortion services. There is no evidence that legislators intended to prohibit coverage of abortion in all multi-state plans. Had that been the case, a prohibition would have been explicitly stated in the law.

For this reason, we urge the Department to clarify that multi-state plans are allowed to cover abortion, even if that would result in a lack of uniformity across states. Exempting abortion services from the uniformity requirement is consistent with the Act, which provides unique rules regarding abortion coverage in Section 1303. This clarification will allow state laws prohibiting abortion coverage to stand while, consistent with the intent of the law, allowing issuers of multi-state plans to decide for themselves whether or not to cover abortion.

Catastrophic Coverage

The Secretary should ensure that young women who choose catastrophic coverage have access to the full-range of contraceptive options—a key component of preventive care for women—by including it in the list of recommended preventive services that are covered without cost sharing under Section 2713 of the Affordable Care Act. If contraception is not included as part of the Women's Health Amendment under Section 2713, young women who choose catastrophic coverage will be faced with paying for this essential health care entirely out-of-pocket. Given that fifty-two percent of young women ages 20-29 who use contraceptives depend on prescription contraceptive methods,[3] including contraception in the Women's Health Amendment under Section 2713(a)(4) would meet a fundamental health care coverage need for a large segment of Americans, would help to prevent unintended pregnancies, and would improve the health of these young women.

In addition, the Secretary should include all obstetric and gynecological providers in the definition of primary care in the catastrophic coverage provision created by Section 1302. The catastrophic coverage provision of the Affordable Care Act allows enrollees coverage of three primary care visits per year without having to pay towards the deductible. Routine OB/GYN annual exams are primary care visits for women, and are widely recognized as such by states and the federal government. The Affordable Care Act recognizes that obstetric and gynecological care is primary care by giving women direct access to such care. This is now in line with the twenty-two states and the District of Columbia that require obstetric and gynecological services to be treated as primary care.[4] By including obstetric and gynecological annual exams in the definition of primary care, HHS will ensure that young American women have catastrophic coverage that is on par with their male counterparts.

CONSIDERATIONS REGARDING ELIGIBILITY AND ENROLLMENT AND OUTREACH

Sections G of the Request for Comments ask for feedback regarding eligibility and enrollment and Section H requests feedback regarding outreach, both areas that have implications for reproductive health access. Essential community providers, including publicly funded family planning health centers, provide essential health care to millions of women and men each year. In 2008, over 7 million female patients received publicly funded family planning services at these health centers, including 4.7 million served by

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[3] *See*, William D. Mosher & Jo Jones, U.S. Dep't of Health & Human Servs., *Use of Contraception in the United States: 1982-2008*, Vital and Health Stat., Aug. 2010, at 27, *available at* http://www.cdc.gov/nchs/data/series/sr_23/sr23_029.pdf.

[4] Kaiser Family Found., *State Mandated Benefits: OB/GYNs as Primary Care Providers, 2008*, Kaiser State Health Facts, Feb. 2008, http://www.statehealthfacts.org/comparemaptable.jsp?ind=494&cat=10.

the Title X program.[5] More than 6 in 10 patients who receive care at a family planning health center consider it their usual source of health care.[6]

The experiences of these health centers and the patients that they serve inform our comments about enrollment and eligibility and outreach. Their experiences not only highlight the important role that community-based organizations play in health program enrollment, they offer valuable insights in how to ensure state-based health insurance Exchanges operate most effectively. In particular, the 27 states that have expanded access to family planning services through Medicaid have important lessons to share about the opportunities and challenges of greater access to health care coverage and how to reach out to underserved populations.

Of note, burdensome citizenship documentation requirements create barriers to care. As noted by the Center on Budget and Policy Priorities in analyzing the results of citizenship documentation requirements eight months after DRA implementation, an increasing number of states reported marked declines in Medicaid enrollment. A recent study in Oregon demonstrated a 33% decline in family planning visits when patients were required to produce documents for citizenship verification.[7] Teens in particular who were required to produce documentation of citizenship very often do not return to receive their confidential medical services; simply the requirement of documentation, itself, has been shown to cause a sharp decline in teens seeking access and receiving services for family planning.[8] "The available evidence strongly suggests that those being adversely affected are primarily U.S. citizens otherwise eligible for Medicaid who are encountering difficulty in promptly securing documents such as birth certificates and who are remaining uninsured for longer periods of time as a result."[9]

With these experiences and lessons in mind, we offer the following recommendations regarding Enrollment and Eligibility (Section G) and Outreach (Section H):

- Community-based organizations, including essential community providers like women's health centers, have an enormous role to play in educating communities about the coverage and care that is available to them. However, resources must be put in place to ensure these organizations can play a productive role in this process. This includes funding for health information technology and other systems that would serve to streamline and simplify enrollment for consumers.

- The Department should look to best practices in application design to create a simplified application form for the Exchanges, Medicaid, and CHIP.

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[5] Jennifer J. Frost et al., Guttmacher Inst., Contraceptive Needs and Services: National and State Data, 2008 Update 3 (2010), *available at* http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf.

[6] Rachel Benson Gold et al., Guttmacher Inst., Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System 4 (2009).

7 Lisa Angus & Jennifer DeVoe, *Evidence that the Citizenship Mandate Curtailed Participation in Oregon's Medicaid Family Planning Program*, 29 Health Aff. 690, 694-97 (2010).

8 *Id*.

9 Donna Cohen Ross, Ctr. on Budget & Pol'y Priorities, New Medicaid Citizenship Documentation Requirement is Taking a Toll: States Report Enrollment Is Down and Administrative Costs Are Up 1 (2007), *available at* http://www.cbpp.org/cms/?fa=view&id=1090.

- Strong data linkages with other agencies that can provide income and citizenship data to verify eligibility must be established, while protecting confidentiality.

- Exchanges should be required to amend their agreements with the Social Security Administration (SSA) and the Department of Homeland Security (DHS) to allow data matching to verify citizenship or immigrant status, and to only require documentation from the enrollee if status cannot be resolved through those systems. All states already have agreements in place with the SSA for data matching in Medicaid and CHIP. States also have agreements in place with DHS to verify immigrant status through the SAVE system. These existing agreements could be amended to cover enrollees in the Exchanges and not have to require documentation directly from applicants unless the data matching does not verify an appropriate eligible status. In addition, in no case can the requirements for citizenship documentation for Exchange access be more stringent than they currently are under Medicaid and CHIPRA.

- Phone, mail, and in-person options for completing the enrollment application must be robust and provide the same level and quality of information that can be found online.

- The Department should consider the extent to which presumptive eligibility is possible for individuals applying for Exchange-based health plans, and should incorporate lessons from the successes in Medicaid and CHIP.

- To the extent such assistance is provided, health care providers should be able to receive grant funding or additional reimbursement for assisting patients with eligibility and enrollment.

- State Exchanges should consider essential community providers as key stakeholders to consult about Exchange operations and should look to them for best practices regarding reaching out to and enrolling hard-to-reach populations.

- Linguistic competency, including translation services and interpreter services, must be required in web portals, outreach materials, and marketing materials.

EMPLOYER PARTICIPATION

The Department has requested information about issues of interest to employers with respect to their participation in an Exchange. We urge you to reiterate to employers the importance of employee choice in any decision to allow their employees to participate in an Exchange. Section 1312(a)(2) makes clear that, while a qualified employer participating in an Exchange may determine the *level* of coverage to be made available to employees, it is the employee's decision as to which QHP he or she chooses within that level. It would be in direct violation of the statute, as well as the core purpose of the provision, if any exception were made that would allow a participating employer to limit the choices available to his or her employees on any basis. This principle of employee

choice is a critical one that should be maintained and emphasized. It is also critical to reiterate to employers the importance of keeping employee choices confidential.

REQUIREMENTS FOR WEB PORTALS

The Department has requested comment on what states should consider as they develop web portals for the Exchanges. One important function of the various Internet portals is to present standardized information to consumers that will help them identify and choose the right plan for them. As part of that, consumers will require clear, easily accessible data on the services covered under each plan, including their limitations and exclusions. We recommend the following to ensure that consumers have access to the information they need:

- Federal standards for the development of web portals should set a floor of information to be included, to ensure that all consumers have access to vital information about benefits, including any limitations or exclusions.

- Federal standards for the development of web portals should also ensure that consumers have detailed information on cost-sharing for these services, including prescription drugs.

- The web portals should include information about relevant national- or state-level legal requirements or prohibitions on coverage of specific services under private plans and any other options described (such as Medicaid). Multi-state Exchanges must make clear which policies apply to a given consumer's options.

CONSUMER EXPERIENCE

The Department has requested comment on what best practices in implementing consumer protection standards are needed in the Exchanges. Section 1311(e)(3)(A) requires health plans to make publicly available accurate and timely information on a number of financial functions, including information on cost-sharing and payments with respect to any out-of-network coverage. The transparency requirement should also require plans to make mid-year changes in plan benefits and cost-sharing available to the Exchanges and plan beneficiaries. Mid-year formulary changes are of particular concern to women who depend on routine access to contraceptive services and or supplies, which at this time can have high cost-sharing. A woman who depends on a particular birth control method should be able to adjust her health decisions following changes in the cost-sharing or coverage of the prescription. By requiring health plans to provide timely information to the Exchanges and to plan enrollees, Exchanges will ensure better health access for the participants.

CONFIDENTIALITY FOR SENSITIVE SERVICES

One issue not addressed at all in the Request for Comments is that of confidentiality for reproductive health services and other sensitive care. Numerous studies have demonstrated the importance of confidentiality to the willingness of many teens and young adults to seek out needed care; older adults, too, may seek care that is confidential from a spouse. With the expansion of insurance coverage generally under the Affordable

Care Act, and particularly with the new requirements requiring plans to allow for dependent coverage of children to age 26, the need for confidential care is more vital than ever. However, private insurers make use of claims-processing procedures that may inadvertently undermine confidentiality, notably by sending an explanation-of-benefits (EOB) form to the policyholder (who may be a parent or spouse) when a dependent receives services under the policy.

Federal standards governing the Exchanges provide an opportunity to address this issue. The Department should examine current privacy rules under HIPAA and under state law and policy, including those laws allowing minors to consent to health care, and should work with insurers, state insurance commissioners, employers and health care provider groups, including those with an expertise in pediatric and reproductive care, to identify options for addressing the disconnect between claims-processing procedures and confidentiality.

Thank you for the opportunity to provide comment to the Department as it prepares to establish standards for the development and implementation of Exchanges. We look forward to working with you as you continue to implement the Affordable Care Act.

Sincerely,

American Civil Liberties Union
American Congress of Obstetricians and Gynecologists
Center for Reproductive Rights
EQUAL Health Network
NARAL Pro-Choice America
National Abortion Federation
National Council of Jewish Women
National Family Planning and Reproductive Health Association
National Health Law Program
National Partnership for Women and Families
National Women's Health Network
National Women's Law Center
Physicians for Reproductive Choice and Health
Planned Parenthood Federation of America
Raising Women's Voices for the Health Care We Need