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September 14, 2012

Minnesota Department of Commerce  
Attn: Plan Certification Subgroup  
85 7<sup>th</sup> Place East, Suite 500  
St. Paul, MN 55101

RE: Proposed Certification Requirements for Carriers and Qualified Health Plans

Dear Members of the Plan Certification Subgroup:

The Minnesota Council of Health Plans (“Council” or “we”) appreciates the opportunity to provide comments on the qualified health plan (“QHP”) plan certification recommendations developed by the Plan Certification Subgroup (“Subgroup”) released September 4, 2012. The Council’s membership comprises Minnesota’s seven licensed nonprofit health plans: Blue Cross Blue Shield/Blue Plus of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne, Sanford Health Plan and UCare.

The Council strongly supports the general approach in the recommendations that for 2014 it is necessary to follow existing state laws and rules as the basis for QHP issuer and QHP certification standards. As the recommendations assert, it is not possible for health plans to incorporate new standards and still be able to complete the substantial work necessary to be ready to file products with the state and obtain certification through the Exchange beginning First Quarter 2013. It is critical that health plans know the plan certification requirements to ensure products can be ready for the Exchange by October 1, 2013. Therefore, the Council strongly urges the scope of plan certification standards be limited to what is required under existing federal law and rules.

In addition, Minnesota’s health plans already comply with a number of requirements, many of which are reflected in the recommendations. Duplicative regulations are unnecessary, do not add value for consumers, and do not further consumer protections. The increased administrative burden that they create for health plans must be factored in when considering the timeframe in which health plans will be developing QHPs. Where there are already related federal or state laws in place, the Council recommends that the Exchange refrain from establishing a duplicative requirement for QHP certification.

Finally, the Council would like to take this opportunity to clarify that while we support the Task Force recommendation that market rules and certification requirements be the same inside and outside the Exchange, we understand this recommendation to apply only to QHPs that are offered inside and outside the Exchange. The Council believes that such rules and requirements should not affect the ability of consumers to purchase non-QHPs outside of the Exchange in both the individual and small group markets.

The Council offers the following more specific comments for your consideration.

### **Recommendations on Network Adequacy Certification Standards**

The Council generally supports the network adequacy standards currently required of HMOs under Chapter 62D. However, the Council urges caution in expanding these requirements to include MN Administrative Rules, Part 4685.1010, as they often are not pertinent in the current market and existing insurance product types. For example, the standards for access to emergency care included in 4685.1010, subpart 7 have long been superseded by federal law and the “prudent layperson” standard. Similarly, references in the rule to “referrals” are largely outdated as products today are more commonly open access under which “referrals” are not required. The plan certification requirements should be designed to enhance value for consumers and avoid creating unnecessary administrative burden by applying HMO-specific requirements to non-HMO plans. As such, the Council believes that requirements that are either duplicative or that are inconsistent with the operation of non-HMO plans should not be included in the final plan certification recommendations.

The Council supports updating provider networks in an efficient streamlined process. The recommendations should recognize that the information health plans have is only as current as the information most recently received from providers. The specific timeframe and format for updates should be established with the Exchange in order to take in the necessary logistical considerations.

In addition, the Council recommends that any plan certification requirements for QHPs be those for which compliance is within the health plan’s control. For example, a health care workforce shortage issue may prevent a health plan from meeting rigid network adequacy standards for a given provider type. Plan certification requirements are not the place to solve for workforce shortage issues. The Council agrees it is critical that there be adequate access to necessary provider types and recognizes the challenges related to workforce shortages. However, we believe that this issue is more appropriately addressed through other venues, such as the Work Force Subgroup of the Governor’s Health Care Reform Task Force and other medical education and community forums.

Furthermore, the Future Consideration related to establishing requirements for wait times is unnecessary. As noted on page 6 of the draft recommendations, the accreditation process already includes requirements related to network adequacy and access, which includes existing standards related to access and wait times. Health plans work closely with provider groups to ensure timely access to providers. The Council believes it is unnecessary to duplicate these standards because all QHP issuers will be required to be accredited and already subject to this current standard.

### **Recommendations on Essential Community Providers Certification Standards**

The Council believes the current state standards have served Minnesota well, and supports the recommendation to follow existing state law.

### **Recommendations on Service Area (Minimum Geographical Area) Certification Standards**

The state of Minnesota has a process in place for a health plan to request an exception for a service area containing less than a full county. While the Medicare Advantage county integrity rule is one way to address this issue, the Council believes it is much more effective and efficient to apply the existing state standard and process under state law (MN Stat. § 62D.124) and state rule (MN Administrative Rules, Part 4685.1010,

Subpart 4). As noted above, wherever possible, it is much more efficient and applicable to the needs of our state to apply existing processes already effectively meeting the needs of Minnesotans.

**Recommendations on Accreditation Certification Standards**

The Council agrees that giving health plans three years to complete the robust accreditation process is reasonable and supports this recommendation.

**Recommendations on Enrollment and Termination Certification standards**

The Council agrees that existing state and federal requirements adequately ensure effective enrollment and termination processes and supports this recommendation.

**Recommendations on Benefit Design Certification Standards**

The Council supports the recommendations for 2014. We strongly urge the state to not add additional requirements that would go beyond the essential health benefits package in order to ensure consumers have access to affordable coverage options.

**Recommendations on Rating Variation Certification Standards**

The Council agrees that existing state and federal requirements are sufficient and supports this recommendation.

**Recommendations on Licensure Certification Standards**

The Council agrees that existing state licensure requirements are sufficient and supports the 2014 recommendation. However, it is important to note that those licensure requirements are not only included under MN Statutes, Chapter 62D, but also under Chapters 62A and 62C, depending on the nature of the license. The recommendations should reflect this.

**Recommendations on Rating information Certification Standards**

The Council supports the recommendations related to rating information for 2014.

**Recommendations on Quality Improvement Certification Standards**

The Council supports the Subgroup's recommendation on quality improvement certification standards for 2014.

**Recommendations on Risk Adjustment Certification Standards**

The Council supports the recommendations related to risk adjustment for 2014 and encourages the state to explore a unified data validation process that eases administrative burdens for both providers and health plans.

**Recommendations on Non Discrimination Certification Standards**

The Council supports the recommendations related to nondiscrimination certification standards.

**Recommendations for Marketing Certification Standards**

The Council supports the recommendation to use existing state marketing regulations for the private commercial market.

## **Additional Topics of Interest**

### **Recommendations on Recertification, Decertification, and Non-Renewal Processes**

The Council supports the recommendations to establish an annual or less frequent recertification process and to limit application of the full recertification process. However, the Council seeks clarification of the interaction of the federal regulations and state law. The Exchange regulations at § 156.290 specifically require that “If a QHP issuer elects not to seek recertification with the Exchange, the QHP issuer, at a minimum, must... terminate coverage for enrollees in the QHP.” However, the third bullet point in this section of the draft recommendations would allow enrollees to continue receiving coverage through a decertified or non-renewed QHP, citing the guaranteed renewability requirements under MN Statutes § 62A.65. We seek clarification with respect to how these conflicting state and federal requirements interact.

### **Recommendations on Use of Tribal Addendum as a Component of QHP Certification Standards**

The Council understands that CMS plans to approve a Tribal Addendum and supports the use of that Tribal Addendum once it is approved by CMS and to the extent it incorporates those requirements that do not go beyond what is required under law. It is important to recognize that any addendum developed at the federal level will not take into consideration nation-leading efforts Minnesota has undertaken, including but not limited to quality measurement and administrative simplification. The Council strongly urges the recommendations related to the Tribal Addendum allow for maximum flexibility for health plans and Indian health care providers to voluntarily address these existing state laws and priorities.

### **Recommendations on Easing Transitions Between Public Programs and QHPs**

The Council recognizes the importance of addressing the churn that is likely to occur for some enrollees whose income levels change during the year and who may therefore move between commercial coverage and a Medicaid plan. We are supportive of minimizing difficulties related to moving between the Medicaid and Exchange markets, and believe that assistors will have an important role to play in this capacity. However, while it is appropriate for the Plan Certification Work Group and the Exchange Advisory Task Force to consider the implications of this issue, the Council believes this issue will benefit from a broader policy discussion within the state and that any decisions should ultimately be made in another venue.

With respect to the potential strategy for auto-enrolling individuals from Medicaid into a QHP, we encourage additional discussion on this issue before a recommendation is made. Although this may be a strategy to minimize disruption to individuals and families caused by churn, auto-enrollment would require thoughtful implementation. In particular, any policy would need to address how auto-enrollment is implemented when an enrollee has financial liability in the assigned QHP. Again, we believe it is appropriate for the Plan Certification Work Group and the Exchange Advisory Task Force to consider this issue; however, they should not be the final decision-makers.

### **Information on Streamlining QHP Offerings**

The Council has strong concerns regarding the additional recommendations related to streamlining QHP offerings and believes this consideration is out of scope for the Plan Certification Subgroup. It is critical that health plans know the plan certification requirements for 2014 now in order for health plans to be able to complete the necessary work to develop and file products for approval by the state and certification by the Exchange within an immensely compressed time frame. As such, the Plan Certification Subgroup and Adverse

Selection Work Group should only focus on the 2014 certification recommendations at this time.

The additional recommendations regarding QHP streamlining do not align with the January 18 recommendations of the Health Insurance Exchange Advisory Task Force. Those recommendations specifically state that "market rules should be structured to encourage innovation, competition, and market participation." These additional recommendations, however, completely disregard the Task Force's recommendations by including recommendations that would limit innovation and diminish competition in the marketplace. The recommendations coming out of each of the Task Force's work groups should directly align with the clear objectives defined by the January 18 recommendations.

The Council strongly urges that any study, such as the one included under Recommendations for 2015 and beyond, fully incorporate critical information to ensure a full and balanced report on the impacts of streamlining QHP options. Any study must include at a minimum, but not be limited to:

- An examination of the merits of streamlining overall, without a predisposition in favor of it;
- The impact any streamlining would have on costs and premiums;
- Minnesota specific data;
- An examination of the use of consumer decision support tools, role of assistors, and other ways to increase consumer comprehension of available options; and
- The impact to consumers of limiting choice in the marketplace.

The Council recognizes that health insurance is complicated, but we believe the best means to serving consumers is to find ways to promote consumers' understanding of available choices, rather than to limit those choices.

The Council is committed to working closely with the state as it continues to implement health care reform. Please do not hesitate to contact me directly if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Julie Brunner". The signature is written in a cursive, flowing style.

Julie Brunner  
Executive Director



## Agents Coalition for Health Care Reform

Respond to Agents Coalition  
c/o NAIFA-MN

1405 Lilac Dr No, #121, Golden Valley MN 55422

September 15, 2012

Mr. Michael Rothman  
Commissioner  
Minnesota Department of Commerce  
85 Seventh Place East  
St Paul MN 55101

Dear Commissioner Rothman:

Thank you for the opportunity to comment on the Plan Certification Work Group requirements dated September 4, 2012. We appreciate the opportunity to comment on behalf of the thousands of licensed agents we represent in the state of Minnesota.

The key question before the Plan Certification Work Group is outlined at the bottom of page one of the draft recommendations. It identifies a key observation for the context of the discussions within the subgroup:

"The Exchange Advisory Task Force adopted a recommendation in January 2012 that market rules and certification requirements be the same inside and outside the Exchange in order to prevent adverse selection. This means that recommended QHP certification requirements proposed here, if adopted by the Exchange Advisory Task Force, would apply both inside and outside the Exchange beginning in 2014. Some Subgroup members voiced concern about market-wide application of the recommended standards."

When this recommendation was debated in the Health Insurance Exchange Advisory Task Force in January, 2012, a member of the task force sought clarification on exactly what it meant. This member stated that the recommendation should be read to mean that particular market rules shall apply both inside and outside the exchange; however, the "certification requirements" for qualified health plan (QHP) issuers and QHPs shall apply within the exchange and only to QHPs offered outside the exchange. This task force member made it clear the recommendation shall not be interpreted to apply QHP standards to all individual and small group products offered outside the exchange. Task force members nodded in agreement, no one stated an objection, and they moved on to another recommendation. It is unfortunate this recommendation has been misinterpreted by members of the exchange staff at the Department of Commerce.

Clarifying this discrepancy is central to understanding the context in which the Plan Certification Work Group recommendations would apply in the Minnesota health insurance market. **As such, we request that the Commissioner of Commerce declare if Minnesotans will have access to non-QHPs in 2014 and beyond or**



## Agents Coalition for Health Care Reform

Respond to Agents Coalition  
c/o NAIFA-MN  
1405 Lilac Dr No, #121, Golden Valley MN 55422

Letter to Michael Rothman  
September 15, 2012  
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**not.** Without a definitive answer to this question, the Plan Certification Work Group does not have the clarity it needs to make their recommendations.

Thank you for this opportunity and please feel free to contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads 'Greg Dattilo'.

Greg Dattilo

CC: Chris Schneeman, Chair, Agents Coalition for Health Care Reform

September 17, 2012

Commissioner Michael Rothman, MN Department of Commerce  
State of Minnesota  
St. Paul, MN

Submitted electronically via the [PublicComments.HIX@state.mn.us](mailto:PublicComments.HIX@state.mn.us) email address.

## **Re: Response to Request for Comment Regarding Qualified Health Plan Certification Draft Recommendations**

Dear Commissioner Rothman:

Blue Cross and Blue Shield of Minnesota (Blue Cross) appreciates the opportunity to comment on the draft qualified health plan (QHP) recommendations released September 4, 2012. Blue Cross is a non-profit health service corporation that provides coverage to nearly 2.7 million members. We are the leading health plan company in Minnesota, providing coverage in both the public and private markets.

Blue Cross appreciates that the draft recommendations recognize that it is not possible for health plans to incorporate new standards and still be able to complete the substantial work necessary for plans to develop and file products for approval by the state and certification by the Exchange beginning as early as January 2013. Due to the critical need for health plans to know the rules now, the Exchange Task Force and its work groups should only focus on the certification standards minimally required under federal law for 2014 at this time.

Blue Cross supports the comments submitted by the Minnesota Council of Health Plans (Council). In addition, Blue Cross strongly supports the draft recommendations that directly align with current state law, and we offer the following more specific comments for your consideration.

### **Recommendations on Network Adequacy Certification Standards**

#### Application of HMO Standards

Blue Cross generally supports the network adequacy standards currently required of HMOs under Chapter 62D. However, Blue Cross is concerned with the broader application of the HMO licensure requirements, under MN Administrative Rules, Part 4685.1010, to non-HMO plans for network adequacy requirements. Many of these additional requirements are no longer relevant in the current market or to existing insurance product offerings.

Specifically, there are both state and federal laws that currently require access to emergency care. Duplicative regulations are unnecessary, do not add value for consumers, and do not further consumer protections. The increased administrative burden that they create for health plans must be factored in when considering the timeframe in which health plans will be developing QHPs. Where there are already related federal or state laws in place, Blue Cross recommends that the Exchange refrain from establishing a duplicative requirement for QHP certification.

In addition, the requirements related to referrals are largely outdated as products today are more commonly open access without referral requirements and do not apply in the non-HMO market. The

QHP certification requirements should be designed to enhance value for consumers and avoid creating unnecessary administrative burden by applying HMO-specific requirements to non-HMO plans. Requirements specific to HMOs plans seeking QHP certification will still apply under current HMO laws and rules. Therefore, Blue Cross believes existing state HMO requirements that lack applicability to non-HMO plans should be excluded from the final QHP certification recommendations.

Finally, it is critical that any network adequacy requirements not be overly restrictive so as to hinder the development of innovative payment reform and care delivery models. Flexibility is especially important in greater Minnesota to allow for new and emerging care delivery models that meet the needs of underserved areas. Minnesota has long been a national leader in health care, and the QHP certification requirements should allow for continued flexibility to ensure meaningful access to high quality, low cost care for all Minnesotans.

#### Provider Network Updates

Blue Cross recognizes the need to ensure consumers have the necessary information related to provider networks when selecting a health plan, and we strive to ensure our network directories are up to date. Within any recommendation, it is important to recognize that the information health plans have is only as current as the information most recently received from providers. The specific logistical requirements related to timing and format for updates should be established between the QHP issuer and the Exchange in order to take in the necessary logistical considerations related to the IT infrastructure capabilities of the Exchange, once any limitations are known and ready for testing and related to the timing of updates from plans. Blue Cross believes this will best ensure necessary updates to provider network directories are done in an efficient and streamlined process.

#### Future Considerations for Network Adequacy

Blue Cross recommends QHP certification standards focus only on those requirements for which compliance is within the direct influence of the health plan. We agree that adequate access to all necessary provider types throughout the entire state is critical and recognizes the related challenges. However, shortages of key provider types, including but not limited to specialists or culturally competent providers, are more appropriately addressed within a broader public policy context to assist in establishing appropriate incentives and training opportunities to address key workforce shortages. Creating a requirement on QHP issuers fails to address the underlying issues. This is a much larger issue that must be addressed within a broader context.

Similarly, health plans lack control over wait times at specific provider offices. As noted on page 6 of the draft recommendations, the robust accreditation process already includes requirements related to network adequacy and access, including existing standards specific to access and wait times. In addition to ensuring a choice of network options for our members, we work closely with our provider groups to ensure timely access to necessary services and providers. Blue Cross believes it is unnecessary to duplicate these standards because all QHP issuers will be required to be accredited and already subject to this current standard.

#### **Recommendations on Service Area Certification Standards**

Blue Cross supports a competitive marketplace that ensures a level playing field. Utilizing state standards related to service areas is reasonable as long as the process prevents the capability for a carrier to risk select through limited services areas. These standards should promote fair and level competition, while limiting any additional administrative burden.

The state of Minnesota has an existing process in place for a health plan to request an exception for a service area containing less than a full county, under Minnesota Statutes § 62D.124 and Minnesota

Administrative Rules, Part 4685.1010, Subpart 4. While the Medicare Advantage county integrity rule is one way to address this issue, Blue Cross believes it is much more efficient to apply existing processes already effectively meeting the needs of Minnesotans and ensuring a competitive marketplace.

#### **Recommendations on Benefit Design Certification Standards**

Blue Cross supports the recommendations for 2014. While we recognize the essential health benefits (EHB) discussion is occurring primarily within the Governor's Health Care Reform Task Force Access Work Group, we strongly urge the state to avoid additional requirements that would go beyond the EHB package. While the EHB package requirements will ensure consumers have access to a standard level of coverage, meaningful access to coverage is premised on the affordability of coverage options. If additional requirements are placed on the EHB package, consumers will ultimately face limited options due to the increased costs associated with added requirements. Going forward, maintaining access to affordable coverage will require a close review of existing benefit standards to ensure these requirements are warranted by the clinical evidence.

#### **Recommendations on Quality Improvement Certification Standards**

Blue Cross supports the Subgroup's recommendation on quality improvement certification standards for 2014. As the Measurement and Reporting Work Group continues to examine this issue, we recommend the work group look to existing community standards such as those developed by Minnesota Community Measurement and those relied upon through the accreditation processes of NCQA and URAC.

#### **Recommendations on Risk Adjustment Certification Standards**

Blue Cross supports the recommendations related to risk adjustment for 2014. Additionally, we strongly encourage the state to explore a unified data validation process that eases administrative burdens for both providers and health plans even under a federal risk adjustment program. Creating efficiencies wherever possible helps to ensure reduced costs within the overall health care system.

#### **Additional Topics of Interest**

##### **Recommendations on Recertification, Decertification, and Non-Renewal Processes**

Blue Cross supports the recommendations to establish an annual or less frequent recertification process that limits application of the full recertification process to only when full review is necessary.

As is raised within the Council letter, Blue Cross also seeks clarification of the interaction of the federal regulations and state law. The final Exchange regulations at § 156.290 specifically require that "If a QHP issuer elects not to seek recertification with the Exchange, the QHP issuer, at a minimum, must... terminate coverage for enrollees in the QHP." However, the third bullet point in this section of the draft recommendations would allow enrollees to continue receiving coverage through a decertified or non-renewed QHP, citing the guaranteed renewability requirements under MN Statutes § 62A.65. We seek clarification with respect to how these conflicting state and federal requirements interact.

##### **Recommendations on Use of Tribal Addendum as a Component of QHP Certification Standards**

Blue Cross recognizes the unique applications of federal law related to Indian health care providers. We support the use of the CMS-approved Tribal Addendum to the extent it incorporates those requirements that do not go beyond what is required under law.

It is equally important to recognize that any addendum developed at the federal level will not take into consideration Minnesota's nation-leading efforts, including but not limited to the work of Minnesota Community Measurement, the Institute for Clinical Systems Improvement, or the Administrative Uniformity Committee. Blue Cross strongly urges the recommendations related to the Tribal Addendum

allow for maximum flexibility for health plans and Indian health care providers to voluntarily address these existing state standards and priorities.

### **Recommendations on Easing Transitions Between Public Programs and QHPs**

Blue Cross believes it is necessary to minimize “churning” or the movement between public programs and commercial coverage due to mid-year income changes. The Exchange, assistors, health plans, and providers are all critical to identifying these individuals as early as possible to avoid unnecessary and avoidable gaps in coverage. We are supportive of strategies to minimize difficulties related to moving between Medicaid and the commercial market. However, we believe it is necessary to fully examine the impact of potential strategies, including auto-enrollment of an individual from Medicaid into a QHP, which will result in financial liabilities for those individuals. Blue Cross also supports considering this issue in a different venue and within the broader context of the future of MinnesotaCare and a potential Basic Health Program.

### **Information on Streamlining QHP Offerings**

Blue Cross has strong concerns regarding the additional recommendations related to streamlining QHP offerings and believes this consideration is out of scope for the Plan Certification Subgroup. As discussed above, timely completion of plan certification requirements for 2014 in the next 60 days is essential to ensure health plans are able to complete the necessary work to develop and file products for approval by the state and certification by the Exchange within an immensely compressed time frame. As such, the Exchange Task Force and its work groups should only focus on the 2014 certification recommendations at this time.

Moreover, the additional recommendation regarding QHP streamlining for 2015 and beyond does not align with the January 18 recommendations of the Health Insurance Exchange Advisory Task Force. Those recommendations clearly state that "Market rules should be structured to encourage innovation, competition, and market participation." Streamlining QHP offerings – essentially standardizing product offerings – would have the opposite effect by limiting innovation and diminishing competition. The QHP certification recommendations should align with the clear objectives defined by the January 18 recommendations.

We strongly support the recommendation of the Council that any study that is conducted on the impacts of streamlining QHP options should ensure a full and balanced report on the impacts of streamlining QHP options and, at minimum, must include::

- An examination of the merits of streamlining overall, without a predisposition in favor of it;
- The impact any streamlining would have on costs and premiums;
- Minnesota specific data to support market specific analysis;
- An examination of the use of consumer decision support tools, the role of assistors, and other ways to increase consumer comprehension of available options; and
- The impact to consumers of limiting choice in the marketplace.

Finally, it is critical that QHP certification requirements continue to provide the flexibility for health plans to drive value through innovative plan designs and payment reform. For example, as part of Provider Peer Grouping, the state encourages health plans to create incentives for the use of high quality, low cost providers – driving value and improved outcomes. Limiting the ability of health plans to design alternative product offerings may unintentionally discourage the use of these types of value-based insurance designs. Blue Cross recognizes that health insurance is complicated, but we believe the best means of serving consumers is to identify opportunities to promote consumers’ understanding of available choices and to choose plans based on their preferences, rather than to limit those choices.

Blue Cross appreciates your consideration of our comments on the draft recommendations for plan certification. If you have any questions about this letter or if we can provide further assistance, please contact me at 651.662.8786 or [Scott\\_Keefe@bluecrossmn.com](mailto:Scott_Keefe@bluecrossmn.com).

Sincerely,

A handwritten signature in black ink that reads "Scott A. Keefe". The signature is written in a cursive style with a long horizontal line extending to the right.

Scott Keefe  
Vice President, Policy & Legislative Affairs



MINNESOTA  
CHAMBER of  
COMMERCE

September 17, 2012

Katie Burns  
Department of Commerce  
85 7th Place East, Suite 500  
St. Paul, Minnesota 55101

Dear Ms. Burns:

Thank you for the opportunity to comment on the September 4, 2012, recommendations put forth by the Health Insurance Exchange Advisory Task Force's Plan Certification Work Group.

The Minnesota Chamber of Commerce represents approximately 2200 businesses, nearly 80 percent of which are small employers eligible for exchange participation. The Chamber supports a Minnesota health insurance exchange that promotes better health outcomes, makes coverage more affordable, and preserves consumer choice. The Plan Certification Work Group's recommendations directly impact these goals.

In shaping plan certification recommendations, the Chamber respectfully requests that the work group consider the position in which employers and their employees will find themselves in 2014 and beyond. The state's own actuarial analysis of how the ACA impacts Minnesota indicates that 55 percent of small employers will see increased premiums due to different rate calculations and that approximately one-fourth will be required to "buy up" health insurance to meet new cost-sharing requirements. Additional restrictions, such as limitations on the use of pre-tax health care accounts offered to small employers and large taxes and assessments to finance the ACA, lead to one result: increased costs for small businesses that continue to offer health insurance to employees. The Chamber hopes that in putting forth its recommendations the work group focus on: maximizing consumer choice, promoting affordable coverage, and meeting minimum ACA requirements for 2014. These goals are best accomplished by preserving the greatest possible diversity in products, carriers, and distribution channels.

### Scope

Establishing a state health insurance exchange carries a broad array of complicated and, at times, controversial tasks. Even meeting minimum ACA requirements to prepare for a 2014 launch will be challenging. The work group has recognized that a distinction exists between basic, required tasks for 2014 and elective policy decisions that could be implemented in 2015 and beyond. Given the complexity and seismic changes plan certification recommendations

carry, the Chamber respectfully suggests that, for now, the work group limit its activities to providing only recommendations necessary to implement minimum ACA requirements for 2014. To go beyond the scope of federal requirements at this time creates unnecessary burdens and controversies that undermine the process of building an effective, functional exchange ready to serve consumers in 2014.

## **Recommendations**

Current work group recommendations raise some concerns because they conflict with the goal of providing diverse, affordable product choices to consumers. The following, while not comprehensive, highlights a few of the Chamber's concerns with and corresponding suggestions for improvement to the current recommendations.

### ***"Streamlining" versus Consumer Choice***

The current recommendations present the concept of "streamlining" qualified health plan (QHP) options. This concept is troubling because it potentially leads to limiting choice, which hurts consumers.

First, the work group expressed concern that too many products may overwhelm consumers and that "streamlining" may be necessary to simplify the consumer experience. The Chamber respectfully but strongly disagrees. Consumers are competent. They like and benefit from choices. Many rely on diverse options to meet their coverage needs. Many will also seek products similar to their current coverage and may be upset to discover limited options prevent them from obtaining the coverage they want or need. On this issue, the work group discussed a "meaningful difference" standard to govern permitted exchange products. This standard is inappropriate because it still limits choice. It is also vague and could be crafted in ways that, for example, limit access to HSAs and FSAs. Ultimately, eliminating choice disenfranchises consumers by depriving them of products that meet their specific needs and resources.

Moreover, limiting choice is the incorrect approach to simplify the purchasing process. Rather, the exchange infrastructure itself should enable consumers to buy insurance in an accessible, straightforward manner. The state has committed more than \$40 million to build a website designed to simplify the consumer experience and will develop a call center to assist consumers further with purchasing and enrollment. Also, many consumers will continue to work with brokers who already possess the expertise to guide individuals and small employers who desire further assistance in purchasing coverage. If the exchange functions as the ACA requires, there is no need to limit consumer choice in the name of simplicity; the system itself will generate simplicity.

Second, limiting choices makes care less affordable. Consumers benefit from choice because more choice fosters greater competition and leads to more affordable coverage. Limiting choice runs counter to Minnesota's goal of making coverage more affordable, especially for fully-insured market consumers.

Third, the ACA does not require limitation or “streamlining” of QHPs. Thus, to discuss “streamlining” Minnesota exchange products is premature, especially when more timely issues remain unresolved. There is no reason—based on federal requirements, policy benefits, or consumer concern—to limit consumer choice by “streamlining” exchange products.

Finally, the recommendations for 2015 and beyond suggest the exchange commission a study of the advantages and disadvantages of different approaches to benefit “streamlining.” The language implicitly endorses the concept of limiting consumer choice. It also creates an unnecessary study to be commissioned by a governance body yet to be created and sustained by funding yet to be provided. Because it is biased towards a controversial concept and lacks the infrastructure for execution, the recommendation should be removed.

*The Chamber respectfully requests that recommendations to “streamline” QHPs and study the “advantages and disadvantages of different approaches to benefit streamlining” be removed. The recommendations should focus on how to comply with related minimum ACA requirements for 2014.*

### **Adverse Selection: Markets Inside and Outside the Exchange**

The current recommendations highlight another important topic: whether QHP certification applies only to exchange products and whether non-QHPs may be sold outside the exchange. The Chamber respectfully suggests that certification should apply only to QHPs, that non-QHPs should be permitted to the full extent allowed under existing state law, and that a robust marketplace that fosters innovation should be maintained outside the exchange. A few related points are important to note.

First, the work group’s current recommendation requires clarification regarding its invocation of a January Task Force recommendation. The work group recommendation states that “The Exchange Advisory Task Force adopted a recommendation in January 2012 that market rules and certification requirements be the same inside and outside the exchange in order to prevent adverse selection.” In debating the January recommendation, a Task Force member clarified that the recommendation would *not* be interpreted to allow the exchange to apply new product rules outside the exchange. In other words, the exchange would and should not regulate all products sold in Minnesota’s individual and small group markets. All Task Force members agreed; no one objected to the clarification. Given the work group’s subject matter, it is appropriate for the group to include this clarification in referencing the Task Force’s January recommendation.

Second, the work group indicates that plan certification rules should apply inside and outside of the exchange equally to avoid adverse selection. This recommendation is a radical departure from current markets and state law. A state exchange should promote informed purchasing and facilitate coverage enrollment. It should not be used as a tool to limit consumer choice, within and especially outside an exchange. Such a recommendation would stifle innovations and deprive consumers of coverage options. Moreover, the recommendation overreaches. The ACA already imposes mechanisms to avoid adverse selection. State rules similarly protect

against adverse selection. Additional regulations are unnecessary and potentially harmful to consumers.

Third, the recommendation is hasty given that the exchange's governance structure is unknown. To recommend that an entity not yet created or authorized under law to effectively control the state's insurance market is inappropriate and deeply concerning.

*The Chamber respectfully requests that the recommendation be amended to clarify that the Task Force's January recommendation does not permit the exchange to apply product rules outside the exchange. It further requests that the work group strongly underscore that certification requirements apply only to QHPs and that non-QHP products may be offered outside the exchange.*

### **Other Recommendations**

In the interest of brevity, the Chamber will not provide extensive comments on the remaining recommendations, especially as they remain works in progress. Rather, the Chamber respectfully suggests that as the work group moves forward, it reevaluate its approach to plan certification discussions. Currently, recommendations around network adequacy, service areas, and benefit design generally contemplate additional rules and regulations. A more effective approach may be to identify existing rules and regulations, how they interact with ACA requirements, and what rules and regulations are appropriate for repeal or implementation to meet state needs and exchange requirements going forward.

The Chamber appreciates the complex issues facing the work group and the substantial time members have devoted to discussing this topic. Thank you for your consideration of these comments.

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johansen", with a long horizontal flourish extending to the right.

Kate Johansen  
Manager of Health and Transportation Policy



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September 14, 2012

Katie Burns  
Exchange Measurement and Reporting Director  
Minnesota Department of Commerce  
85 7th Place East Suite 500  
St Paul, MN 551012198

Dear Ms. Burns,

Thank you for soliciting public input on the “Proposed Certification Requirements for Carriers and Qualified Health Plans Recommendations of the Plan Certification Subgroup” in advance of those draft recommendations being forwarded to the full Adverse Selection Workgroup. The HealthPartners family of healthcare companies serves more than one million medical and dental health plan members nationwide. It is the largest consumer-governed, nonprofit health care organization in the nation, providing care, coverage, research and education to improve the health of members, patients and the community. We have had the opportunity to be represented on the Plan Certification subgroup and our comments reflect our many hours of discussion in that forum. In presenting our comments, we begin with three overarching concerns and then move to specific issues.

### ***Overarching Comments***

First, HealthPartners believes that there are a broad array of basic tasks that the Minnesota Exchange must complete in time for 2014 Exchange launch. The Plan Certification Subgroup recognized the complexity and challenges inherent in many of those basic tasks, including establishing workable Plan Certification recommendations. This is reflected clearly in the division between “Recommendations for 2014” and “Recommendations for 2015 and Beyond”. We recommend that the Adverse Selection Workgroup take this further to **only put forward recommendations on Plan Certification that address compliance with the Plan Certification Standards required under the ACA** and not go beyond that for at least 2014 and perhaps 2015 as well. Including additional and potentially controversial criteria for Qualified Health Plans (“QHP”) or issuer certification beyond the list of federally required criteria should be out of scope for now.

One key example of the need to focus on required standards only is the concept of “Streamlining of QHP Offerings” which was discussed by the subgroup and is presented in these Recommendations. That concept is not among the required certification standards under the ACA. HealthPartners believes that choice is a critical feature for consumers. Limiting choice is not the way to create a successful marketplace. Providing the right tools and assistance to enable consumers to make good choices among a wide variety of options is the true strength of a functioning marketplace. We believe that streamlining is neither necessary nor appropriate. At a minimum, for the purposes of these Recommendations, the topic of streamlining product designs should be noted as being beyond the requirements of the ACA for certification and instead be noted as one of many options for discussion after 2015 and beyond.

Another reason to stay focused only on required Plan Certification elements in these Recommendations is the competitive disadvantage at which an extended array of requirements would put Minnesota based plans. Multi-State plans and CO-OPs will likely not have to meet state Plan Certification requirements – at least not all of them. This places an unfair burden on Minnesota plans to compete against these new options which function under different rules. The Marketplace which Minnesota is constructing should not begin by disadvantaging the plans which have served Minnesotans for many years.

Second, this document should make clear that **these certification requirements apply to QHPs only and that there can be non-Qualified Health Plans offered outside of the Exchange**, which is supported by current state law. The recommendation that went forward from the Adverse Selection Work Group and was adopted by the Health Insurance Exchange Task Force implied that these certification requirements would apply to any and all products offered inside and outside the Exchange in the individual and small group market. In other words, there would be no non-QHPs available in either the individual or small group market. This is a radical change from the market that exists today. The premise of the Exchange is as a “marketplace for individuals and businesses to compare, choose, and buy affordable health insurance”, including access to federal subsidies and small business tax credits. However, for those individuals for whom a tax subsidy is not an option or for small employers not eligible for tax credit, their plan choices should not be limited only to those product options that are available on the Exchange. Currently, hundreds of thousands of individuals and small group enrollees have coverage through a broad array (hundreds) of different product and plan designs. It is inconceivable that the workgroup intended to require that in the future, the only products that could be offered in either the individual or small group market would be products that were approved to be sold on the Exchange.

The reason given for this recommendation (to apply plan certification rules in and out of the Exchange) was to avoid adverse selection. Adverse selection is a reality of any insurance marketplace and it is appropriate for stakeholders to discuss ways to minimize the effects of adverse selection on the post-2014 market. In 2014, we will face a different, but manageable, set of adverse selection issues. These can be alleviated through a variety of mechanisms, such as similar open enrollment rules in and out of the Exchange, but does not necessitate that every plan in the marketplace meet QHP standards. New reinsurance, risk adjustment and risk corridor programs will also serve to protect the Minnesota market from adverse selection.

Stifling innovation and purchaser choice is not the way forward. Just because the recommendation was adopted does not mean that it should not be revisited in light of this understanding. We strongly suggest that the Adverse Selection Workgroup do so.

***Specific Comments:***

In general, we support the recommendations that set standards at current state and federal law. We have the following specific comments on areas where these recommendations go beyond that.

**Recommendations on Network Adequacy Certification Standards**

HealthPartners is generally supportive of the Recommendations for 2014. However, we believe that provider network update formats and timelines should be established between the Exchange and plans based on both information available, IT capabilities and other factors. We appreciate the need for members and prospective members to know providers in the network at the time that they are choosing coverage or need care. The health plans themselves maintain as close to real time information as is

available on their web sites. We should not create additional administrative burden by requiring frequent updates until there is seamless connectivity in a streamlined format between the Exchange and the QHP issuers.

In the Future Considerations, there is reference to innovative access models which we strongly support. However, there is a reference to more specific requirements for timely access to care. This is already included in the Accreditation Standards required by NCQA and URAC and should not be revisited under plan certification.

#### **Recommendations on Service Area (Minimum Geographical Area) Certification Standards**

Under the Recommendations for 2014, there is a suggestion that for service areas smaller than a county, the State consider using the Medicare “county integrity rule”. We do not believe that this is necessary. **The State of Minnesota already has a process in place for a health plan to request an exception for a service area containing less than a full county.** While the Medicare Advantage county integrity rule is one way to address this issue, HealthPartners believes it is much more effective and efficient to apply the existing state standard and process under state law (MN Stat. § 62D.124) and state rule (MN Administrative Rules, Part 4685.1010, Subpart 4). As noted above, wherever possible, it is much more effective and applicable to the needs of our state to apply existing processes already effectively meeting the needs of Minnesotans.

Relative to the Future Considerations, HealthPartners strongly recommends that there be **no connection between rating area and service area**. They are two very different concepts and are based on very different criteria. There would be no confusion for those coming to the Exchange because there will be one set of products available for their area with one set of rates. It does not matter that the products and/or rates for those products will be different for someone living in another part of the state where provider contract rates are significantly different.

#### **Recommendations on Accreditation Certification Standards**

We agree that giving health plans three years to complete the robust accreditation process is reasonable and supports this recommendation.

#### **Recommendations on Benefit Design Certification Standards**

We support the Recommendations for 2014. However, we urge the state to not add additional requirements that would go beyond the essential health benefits package, particularly consideration of standardization of benefits and cost-sharing. We believe that robust plan choice architecture in the Exchange online modules can more than adequately address narrowing of choices to those of most interest to an individual. In addition, there will be assisters (navigators and agents/brokers) to help people choose among the plans that are most appropriate for them. We don’t need to artificially limit options as they have in a few other states. Minnesota has had a variety of options for years and a relatively low uninsured rate. The number of choices is not what is driving lack of coverage among the uninsured.

#### **Recommendations on Licensure Certification Standards**

HealthPartners believes that existing state licensure requirements under 62A, 62C and 62D are sufficient and supports this recommendation. In reference to the comment under Future Recommendations, we would like to point out that while we, and other stakeholders, strongly support the non-profit status of health plans in Minnesota, no matter what the state decides on this, at least one Multi-State plan will be

for-profit. As a result, ensuring a level playing field across all plans is a critical issue to ensure competitive options for consumers.

### **Recommendations on Risk Adjustment Certification Standards**

We support the recommendations related to risk adjustment for 2014 and encourages the state to explore a unified data validation process that eases administrative burdens for both providers and health plans.

### **Additional Topics of Interest**

#### **Recommendations on Recertification, Decertification, and Non-Renewal Processes**

HealthPartners supports the recommendations to establish an annual or less frequent recertification process and to limit application of the full recertification process. However, we seek clarification of the interaction of the federal regulations and state law. The Exchange regulations at § 156.290 specifically require that "If a QHP issuer elects not to seek recertification with the Exchange, the QHP issuer, at a minimum, must... terminate coverage for enrollees in the QHP." However, the third bullet point in this section of the recommendations would allow enrollees to continue receiving coverage through a decertified or non-renewed QHP, citing the guaranteed renewability requirements under MN Statutes § 62A.62. We seek clarification with respect to how these conflicting state and federal requirements interact.

#### **Recommendations on Use of Tribal Addendum as a Component of QHP Certification Standards**

We understand that CMS plans to approve a Tribal Addendum and supports the use of that Tribal Addendum once it is approved by CMS and to the extent it incorporates those requirements that do not go beyond what is required under law.

#### **Information on Streamlining QHP Offerings**

HealthPartners has strong concerns regarding the additional recommendations related to streamlining QHP offerings. The concept of "limiting product choice" (which is what streamlining really means) does not align with the January 18 recommendations of the Health Insurance Exchange Advisory Task Force. Those recommendations specifically state that "market rules should be structured to encourage innovation, competition, and market participation." These streamlining recommendations, however, completely disregard the Task Force's recommendations by including recommendations that would limit innovation and diminish competition in the marketplace. The recommendations coming out of each of the Task Force's work groups should directly align with the clear objectives defined by the January 18 recommendations.

We also believe strongly that any study on plan design limitation, such as the one included under Recommendations for 2015 and Beyond, fully incorporate critical information to ensure a full and balanced report on the impacts of streamlining QHP options. Any study must include at a minimum, but not be limited to:

- An examination of the merits of streamlining overall, without a predisposition in favor of it;
- The impact any streamlining would have on costs and premiums;
- Minnesota specific data;

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- An examination of the use of consumer decision support tools, role of assistors, and other ways to increase consumer comprehension of available options; and
- The impact to consumers of limiting choice in the marketplace.

We recognize that health insurance is complicated, but we believe the best means to serving consumers is to find ways to promote consumers' understanding of available choices, rather than to limit those choices.

**Recommendations on Easing Transitions Between Public Programs and QHPs**

HealthPartners recognizes the importance of addressing the churn that is likely to occur for some enrollees whose income levels change during the year and who may therefore move between commercial coverage and a Medicaid plan. We are supportive of minimizing difficulties related to moving between the Medicaid and Exchange markets, and believe that Assistors will have an important role to play in this capacity. However, while it is appropriate for the Plan Certification Work Group and the Exchange Advisory Task Force to consider the implications of this issue, we think that this issue will benefit from a broader policy discussion within the state and that any decisions should ultimately be made in another venue.

Again, thank you for soliciting public input. We hope that these comments inform decision making at the Adverse Selection Workgroup and Exchange Task Force levels.

Sincerely,

Stephanie Frost  
Senior Policy Manager

**From:** [Nuri, Khalil](#)  
**To:** [\\*COMM Public Comments HIX](#)  
**Subject:** Plan Certification Work Group Recommendations Comments  
**Date:** Monday, September 17, 2012 8:22:18 AM

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The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to comment on the Plan Certification Work Group recommendations dated September 4, 2012. PhRMA is a voluntary, non-profit organization representing the nation's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives.

We appreciate the work group's effort to engage stakeholders and receive comments on this important subject. The Adverse Selection Work Group has been given recommendations for consideration in its draft document. However, we are concerned about the purpose and intent of several of the work group recommendations related to "Streamlining QHP Offerings" and we offer the following comments in relation to that section:

- **Limiting numbers of Plans sold on the Exchange.** In facilitating the availability of health plans that meet the federal certification requirements, exchanges should accept all plans that meet the certification requirements and not limit the number of plans available to consumers. A broad choice of coverage options will help to facilitate access to quality coverage options.
- **Drug Formulary Streamlining.** Under "Recommendations for 2015 and Beyond," the work group recommends that the exchange commission a study of "the advantages and disadvantages of different approaches to benefit streamlining," including drug formularies. We advise the work group to remove this study, including the portion related to a streamlined drug formulary. PhRMA supports access to comprehensive drug coverage in the state's selection of an Essential Health Benefits benchmark plan and in relation to QHP certification requirements in 2014 and beyond. We question the intent of the state creating a statewide drug formulary for health insurance offered through the exchange and are concerned it may threaten patient access to medicines that prevent, treat, and potentially cure serious and chronic medical conditions.

We appreciate your consideration of these comments. Please feel free to contact me if you have any questions or concerns.

Respectfully Submitted,

/s/

Linda Carroll-Shern J.D.  
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Essential Health Benefits Must Include Comprehensive Prescription Drug Coverage

- **Comprehensive drug coverage leads to better health outcomes.** Countless medical studies have shown the link between patient compliance with prescribed drug regimens and good health outcomes. Barriers to access, including inappropriate coverage restrictions and limits, often decrease patient adherence to needed medical regimens, resulting in poor health outcomes. States should ensure that benchmark policies will not make prescription compliance more difficult for patients. Benchmark policies must cover drugs that physicians decide patients need.
- **Comprehensive drug coverage reduces use of avoidable hospital visits and other costly medical care.** Patients that come off their medicines often require increased doctors' office and emergency room visits as their conditions deteriorate. This can lead to costly, last-minute medical interventions to save patients whose conditions could have been managed more effectively by adhering to drug therapy. As a result, patients that adhere to their prescribed medicine regimens often have lower total medical costs than non-adherent patients.
- **Comprehensive drug coverage is particularly important for patients with chronic disease.** Medication adherence is particularly important for patients with chronic disease, and it is vital that cost-sharing rules account for their ongoing health care needs. Patients with chronic disease often require prescription drug treatments year after year and would face high out-of-pocket costs if their prescriptions were subject to a deductible. Providing prescription drug coverage that is not subject to a deductible will lessen financial barriers to compliance and is also consistent with the Affordable Care Act, which stated that Essential Health Benefits should be similar to typical employer-sponsored coverage. According to a survey by the Kaiser Family Foundation, prescriptions are not subject to a deductible in most employer plans.
- **To realize the clinical and economic benefits associated with comprehensive drug coverage, the benchmark plan must provide access to needed medicines and a meaningful choice of treatments.** The benchmark plan should offer sufficient choice of medicines to provide patients and providers with a range of treatment options consistent with current standards of medical practice, as is customary in the employer market. For example, standards of care established by respected medical professional societies show that the inclusion of only one drug per therapeutic class is insufficient to ensure patient access to needed care. Different patients often respond to drugs in the same class differently, and many conditions require treatment by a combination of medicines in the same therapeutic class. Therefore the benchmark plan must not impose arbitrary restrictions on access to medication.
- **The benchmark plan must not cover prescription drugs in a discriminatory fashion.** The Affordable Care Act forbids qualified health plans from discriminating against individuals based on health care needs. It also requires that benefits must not be designed in a discriminatory fashion. The benchmark plan should not include coverage limits and restrictions that would unfairly burden patients with significant health care needs. For example, the benchmark plan should not impose class-based coverage restrictions that would drive up costs—and hurt access—for patients with complex medical

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conditions in need of combination therapy. Formularies should also not include tiered cost-sharing designed to discourage enrollment among individuals who need specialized medicines, such as those used to treat certain cancers.

- **States should establish clear and meaningful standards for comparing Qualified Health Plans (QHP) to the benchmark plan.** As states evaluate whether a Qualified Health Plan offers coverage on par with the selected benchmark plan, an analysis of actuarial equivalence will not be sufficient. States should develop guidelines for QHPs that reflect multiple aspects of coverage, including the degree of choice available to patients and providers; processes for updating coverage to reflect evolving standards of care; and protections for vulnerable populations. Plans should also have procedures in place to preserve treatment protocols for new beneficiaries and should not be permitted to require patients to repeat step therapy when they change plans. While clear processes to seek exemptions from coverage decisions are necessary to ensure that patients can always receive appropriate treatments, these processes are not a substitute for providing sufficient choice of medicines.



September 17, 2012

Commissioner Michael Rothman  
Minnesota Department of Commerce  
85 7th Place East, Suite 500  
St. Paul, Minnesota 55101

Re: Comments on Proposed Certification Requirements for Carriers and QHPs  
*Submitted via email September 17, 2012 via Exchange Public Comment website*

Dear Commissioner Rothman:

Thank you for the opportunity to submit comments on the Plan Certification Work Group's Proposed Certification Requirements for Carriers and Qualified Health Plans. We appreciate the lengths your staff has gone to move these important questions forward in the Work Group and the Health Insurance Exchange Advisory Task Force.

The Health Benefits Exchange offers tremendous potential to help Minnesota consumers obtain affordable, high-quality health coverage. Key questions related to the design of the Exchange will significantly impact how many consumers use the Exchange successfully to obtain and retain quality health coverage. An Exchange that works well for consumers will offer meaningful, easy-to-understand choices among quality plans; it will resource trusted, community-based assistors to help consumers overcome likely barriers to coverage; it will negotiate on behalf of consumers for the best possible value; and it will link individuals to other key public programs for which many will be eligible. One million Minnesotans will obtain health coverage through the Health Benefits Exchange. These Minnesotans deserve a high-caliber Exchange that is designed first and foremost to serve the consumer.

With the goal of a consumer-friendly Exchange in mind, we would offer the following comments on the workgroup recommendations:

- **Strong network adequacy standards to serve consumers.** We appreciate the attention the recommendations give to geographic access standards. We would urge that quantitative standards also be created for appointment wait times. Thousands of newly insured Minnesotans will enter the health care system in 2014, due to the combined impact of the Exchange, individual mandate, tax credit availability and the public program expansions. These individuals are likely to come with pent-up demand for health care

services, and unduly long wait times would significantly undermine timely treatment and health outcomes. Subjecting an individual to a prolonged wait time for an appointment would not meet a common-sense definition of “adequacy” for that individual’s provider network. Moreover, the ACA requires that health care services be provided “without unreasonable delay,” and the “timely access to care” language does not go far enough to adequately protect consumers or meet this ACA standard. We would urge that the Exchange include a quantitative standard for appointment wait time within the network adequacy standard.

- **Inclusion of Essential Community Providers.** We strongly support the work group’s recommendation that the Exchange adopt the existing state standard established in Minnesota Statutes 62Q.19, requiring all health plans to offer contracts to all state designated Essential Community Providers within their service areas. Individuals who will struggle to access care in 2014 and beyond may have an existing relationship with an Essential Community Provider. Maintaining continuity of care with these providers, especially with culturally competent providers, will result in better health outcomes and help to mitigate health inequities.
- **A robust process for assessment and evaluation of the consumer experience on Qualified Health Plans.** The Exchange has a responsibility under the Affordable Care Act to offer plans that meet the interests of consumers (discussed more fully below). The Exchange cannot meet this requirement without a robust assessment and evaluation of consumer experience on the Exchange, including the experience of consumers enrolled in Qualified Health Plans. We would urge the Exchange to collect empirical data that can fully illustrate the experience of consumers enrolled in QHPs. We would also urge the Exchange to develop an infrastructure for consumer feedback on the QHPs. Both of these sources of data should be studied on a regular basis, and the results should inform the certification, decertification and recertification of QHPs.
- **Limiting options to achieve meaningful choice on the Exchange, beginning in 2014.** A user-friendly Exchange requires meaningful, easy to understand choices. A May 2012 Health Affairs article reports that consumers on the Massachusetts Health Connector fared far better when that Exchange limited the number of health plan options, standardized the products, and provided consumer supports.<sup>1</sup> The Consumers Union has also documented how presenting consumers with too many health plan options actually inhibits an individual’s ability to make a well-informed choice. The Exchange should limit the number of QHPs offered at each metal level – and the number of cost-sharing structures available – to ensure a manageable number of choices and variables for the consumer. Such limitations will also encourage carriers to compete based on quality and value – rather than through the proliferation of plan options. The “meaningful difference standard” does not offer adequate protection against consumers facing an unwieldy number of plan options. We would strongly urge the Exchange to limit the number of plans and cost structures in 2014 so consumers can have a positive experience on the Exchange from its inception.

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<sup>1</sup> “New State Insurance Exchanges Should Follow The Example Of Massachusetts By Simplifying Choices Among Health Plans,” Health Affairs, May 2012.

- **Avoidance of benefit set “holes” by minimizing EHB “substitutions.”**  
Consumers face the unfortunate possibility of carriers choosing to substitute benefits within and across the Essential Health Benefits categories. The greater the number of substitutions that take place, the greater the likelihood that individuals will fall into unexpected “holes” in their health coverage – expecting to have a health service covered that the individual later finds has been “substituted” for something else. The practice of “substituting” within and between benefit categories could also become an unwelcome mechanism of risk selection. We would urge the Exchange to establish clear rules that minimize the practice of “substitution.” We would further urge the Exchange to ensure that these “substitutions” are made clear to consumers.

In addition to these comments on the substance of the recommendations, we would like to offer two comments related to the process for the development of these recommendations.

First, the Affordable Care Act specifically asks states to offer health insurance plans that are in the “interests” of consumers. This is a central provision of the ACA, intended to ensure that the Exchange offers plans – and only plans – that ultimately serve the consumer. The Plan certification work group did not take up the question of what plans are in the “interests” of consumers. We look forward to learning more about what process the Department or Exchange will develop to define what is considered in the “interests” of consumers. We would expect and encourage a conversation of that topic to invite and consider input from a broad and diverse array of Minnesota consumers.

Second, we would raise more generally the importance of more robust consumer participation in the decisions related to what plans are offered on the Exchange, and how those choices are presented. Limiting the discussion of certification requirements to the Health Exchange Task Force and related working groups allows only a limited number of Minnesotans to participate in these important decisions. While the relevant meetings have been open to the public, broad participation has not been actively solicited. In addition, the technical nature of the discussion also significantly constrains the degree of participation allowed to members of the public. A more inclusive and accessible discussion is possible and is needed. We recognize the compressed time schedule within which the Department and the Exchange Advisory Task Force is working. We also recognize significant cost to this process in terms of broad and meaningful consumer participation. As the Exchange Task Force looks beyond 2014, we would urge the development of a process that welcomes much broader participation from members of the public about the appropriate standards for health plans offered within the Exchange. One million Minnesotans will rely on the Exchange for health coverage. Their opinions about the health care choices they will face are valuable and should be considered.

Thank you again for your consideration of this important set of issues.

Sincerely,

Elizabeth Doyle  
Associate Director



September 17, 2012

Minnesota Department of Commerce  
Attn: Plan Certification Workgroup  
85 7<sup>th</sup> Place East, Suite 500  
St. Paul, MN 55101

**Re: Proposed Certification Requirements for Carriers and Qualified Health Plans (QHPs)**

Dear Members of the Plan Certification Subgroup:

UCare appreciates the opportunity to offer comments on the proposed certification requirements for Carriers and QHPs. As context for our comments, UCare is a non-profit health plan working exclusively in state and federal health programs. UCare is the largest health plan administering Minnesota State Public Programs, with over 192,000 members. Additionally, UCare offers the largest Medicare Advantage product in Minnesota to more than 85,000 seniors. In partnership with the state of Minnesota and the Centers for Medicare and Medicaid Services, UCare also administers programs serving seniors dually eligible for Medicare and Medicaid, and non-elderly individuals with disabilities.

Although we do not currently offer any commercial health insurance products, our comments are from the perspective of a potential new entrant in the Exchange marketplace. Overarching our comments on the specific recommendations, UCare strongly supports the Task Force recommendation that market rules and certification requirements inside and outside the Exchange should be the same to encourage fair competition and mitigate adverse selection.

**Recommendations on Network Adequacy Standards**

UCare supports the application of network adequacy standards for Health Maintenance Organizations specified in Minnesota Statutes 62D.124. In the absence of an existing market-wide standard for network adequacy, we view the HMO rule as a sensible and well-tested approach.

**Recommendations on Service Area (Minimum Geographical Area) Certification Standards**

UCare supports a recommendation that service areas for QHPs should generally be no smaller than a county and that service areas need not necessarily be aligned with broader rating areas. As a potential new market entrant without prior commercial products, it would be particularly challenging to secure a commercial provider network for a service area that mirrored a larger rating area. Additionally, there is an existing state standard and process for requesting an exception for a service area less than a full county (MN Statute § 62D.124 and state rule MN Administrative Rules, Part 4685.1010).

**Recommendations on Accreditation Certification Standards**

UCare supports allowing each QHP to obtain the appropriate certification by the third year after the issuer offers a QHP on the Exchange. This timing provides a reasonable amount of time for a new entrant like UCare that has not had a business line that required this type of certification. Three years is an adequate, but not excessive, amount of time to comply with a process that by NCQA's own information is at least an 18 month process.

**Information on Streamlining QHP Offerings**

UCare supports implementation of the strategy option to require carriers offer products that differ from other products offered by the same carrier in some meaningful way (a "meaningful difference" standard). This type of standard is a reasonable compromise in balancing the desire to provide consumers with choice and options to find a plan that will meet their needs, while at the same time not providing an overwhelming number of choices for the consumer to understand, thus impacting consumer experience.

Further, a "meaningful difference" standard would prevent a single carrier from flooding the market with plans that have little difference in plan design elements. In such a scenario, consumers could easily be confused by a profusion of products with little differences.

UCare's support for a "meaningful difference" standard, however, stands in opposition to an arbitrary limit (i.e. a specific number) placed on the number of QHPs one carrier can offer in the Exchange. Artificially controlling the number of plans in the Exchange marketplace is not an approach that will improve consumer understanding of their choices or provide relief from feeling overwhelmed by the process. There are, in fact, other tools that will be available to help consumers make an informed choice. Navigators and the technology infrastructure will help consumers efficiently find a plan that is the best fit for their needs.

**Recommendation of Easing Transitions Between Public Programs and QHPs**

UCare shares the concern that transitions between public and commercial coverage are likely to result in disruptions in the continuity of care and confusion for consumers. In that regard, we are pleased that the Workgroup recognizes the problem, but disappointed that the Workgroup suggests that in the absence of consensus on solutions it will be more viable to explore possible policy and operational issues in 2015 or future years. In our view, delaying further discussion of this issue until 2015 or later is shortsighted with potential significant consequences.

A recent study estimated that within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse; within a year 50 percent, or 28 million, will. In addition, 24 percent will churn at least twice within a year, and 39 percent will experience such churning within two years (Benjamin D. Sommers and Sara Rosenbaum, *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, Health Affairs, 30, no.2 (2011): 228-236).

Similar estimates were reported by Matthew Buettgens, Austin Nichols, and Stan Dorn, *Churning Under the ACA and State Policy Options for Mitigation*, Urban Institute, June 14, 2012.

Given the potential for a substantial volume of transitions between public programs and QHPs, we believe it is not prudent to delay further consideration of possible solutions to 2015 or later. Nor are the two options presented for further discussion the only strategies available to states. There is urgency to resolving the consequences of multiple transitions before the Exchange becomes operational in 2014. Therefore we recommend that DHS, Exchange staff, and the various stakeholders come together and provide thoughtful consideration to a range of policy options and recommendations in 2013.

Again, thank you for this opportunity to provide comments on the QHP certification standards. We look forward to continuing to collaborate with the workgroups and Task Force to find a Minnesota solution to a state-based Exchange.

Sincerely,



Ghita Worcester  
Senior Vice President  
Public Affairs and Marketing