

Attachment
Gary Cohen’s Additional Questions for the Record
Energy & Commerce, Subcommittee on Oversight & Investigations Hearing
“The Center for Consumer Information and Insurance Oversight and the Implementation
of the Patient Protection and Affordable Care Act”
April 24, 2013

The Honorable Fred Upton

- 1. You were questioned repeatedly on the impact of the PPACA on the premiums paid for health insurance—have you or any individuals at CCIIO conducted any research or analysis of the impact of the PPACA on premiums?**

Answer: Issuers have just started to send in their applications for participating in the Marketplaces. We will not know their premium rates for 2014 until after those applications are certified. Likewise, we will not know what premiums outside the Marketplace will be until they are published in each state.

Beginning next year, many individuals will newly receive comprehensive coverage at an affordable price thanks to reduced out-of-pocket costs, premium subsidies, and consumer protections. In addition, the Affordable Care Act has many provisions that help stabilize premiums as new entrants come into the market, such as risk adjustment, reinsurance, and risk corridors. For example, the medical loss ratio (MLR or 80/20) rule, which is already in effect, will help keep premiums lower.

There have been studies that have made educated guesses about health care costs, but estimates are just that – estimates. In addition, many of these estimates focus on premiums, not the actual out-of-pocket expenses people are going to pay for their plans. Many of these studies do not consider these factors in their projections. Because of the Affordable Care Act, people are going to be able to buy comprehensive insurance without discrimination based on gender or pre-existing conditions. Many of those people will qualify for lower costs on their premiums through tax credits to help them buy insurance, and everyone will benefit from increased transparency and competition both inside and outside of the Marketplace.

- 2. Have you had any discussions with representatives from a health insurance company, or industry representative, discussing the impact of the PPACA on premiums? Identify those individuals and the substance of those conversations.**

Answer: CMS is working continuously with many stakeholders, including health insurance issuers, state departments of insurance, and consumer groups. Our regulations, which were made available for public comment, as well as our guidance materials are available to all stakeholders. In addition, our regulations and guidance materials discuss provisions that help stabilize premiums for issuers, such as risk adjustment, reinsurance, and risk corridors. All our regulations and guidance are available to the public on our website:

<http://www.cms.gov/ccii/index.html>.

- 3. You were asked about the effects of sequestration on your office, and you indicated that you were in a “hiring freeze.” Yet, several job openings are posted online for CMS. Explain this discrepancy. What was the last date a new employee was hired for CCIIO and does CCIIO plan to hire any additional staff in 2013?**

Answer: CMS is under a hiring freeze for most of our accounts including Federal Administration, our main administrative discretionary account. CCIIO FTEs are funded from the following accounts: 1) Federal Administration, 2) Pre-Existing Condition Program (PCIP); 3) Early Retiree Reinsurance Program; 4) Consumer Operated and Oriented Plan (CO-OP) Program; and 5) Exchange Planning and Establishment Grants (1311). Of these accounts, CCIIO is able to fill 23 vacancies currently available under Exchange Planning and Establishment Grants (1311). The remaining accounts are under a freeze, thus, no vacancies are available.

- 4. Have any CCIIO employees been furloughed in 2013?**

Answer: No.

The Honorable Marsha Blackburn

- 1. Pursuant to the Patient Protection and Affordable Care Act (PPACA), an employer must extend affordable health care coverage to basically all of its full-time “employees.” Under the Internal Revenue Code, a leased employee is an individual who is formally hired (and paid) by a third-party leasing agency and to provide service on behalf of the agency’s client, typically on a full-time basis. Moreover, the individual’s work is under the “primary direction and control” of the client (often called the “service recipient”).**

In the proposed regulation for the shared employer responsibility provisions of PPACA, the definition of “employee” indicates that a leased employee will not be treated as the employee of the service recipient, meaning that the service recipient is not required to offer the individual health-care coverage. However, the preamble to the proposed regulation creates an ambiguity as to whether a leased employee may, in some instances, be considered the employee of the service recipient under the common law standard since his/her work is directed and controlled by the service recipient. Can you provide any further guidance as to which entity would be required to offer/provide this type of employee health care coverage?

Answer: CMS is not in a position to comment on the interpretation of proposed regulations issued by the Internal Revenue Service (IRS).

- 2. Recent pronouncements from CCIIO regarding the offer and purchase of the pediatric dental essential health benefit (EHB) have created confusion in the marketplace. Specifically, I understand that inside the federally facilitated exchange (FFE), the pediatric benefit must be offered but its purchase is not required. Outside the FFE, CCIIO staff has made statements that the purchase is mandated—even for childless adults. Can you provide some clarity on CCIIO’s view of the outside the FFE marketplace that is regulated by the state?**

Answer: Several provisions of the Affordable Care Act affect the coverage of pediatric dental essential benefits. Section 2707(a) of the Public Health Service Act requires issuers in the individual and small group markets inside and outside the Marketplaces to offer essential health benefits (EHB) as defined in section 1302 of the Affordable Care Act. EHB requirements apply to health insurance issuers, which must offer certain benefits; they are not requirements for individuals or families to obtain coverage for a particular benefit.

In the EHB Final Rule, CMS provided a clarification regarding situations in which issuers outside the Marketplaces would not be found to be non-compliant with the requirement to offer EHBs if the issuer is reasonably assured that the applicant has obtained the pediatric dental EHB through a Marketplace-certified stand-alone dental plan. With respect to issuers inside a Marketplace, however, section 1302(d)(4)(F) of the Affordable Care Act allows issuers to omit pediatric dental coverage if there is a stand-alone dental plan offering the pediatric dental essential benefit in that Marketplace. Thus, the different issuer requirements in the Affordable Care Act lead to different consumer experiences inside and outside of the Marketplaces.

3. Will the federally facilitated exchanges (FEEs) have information and a link to products providing supplemental coverages, such as stand-alone vision plans (SAVPs), similar to what was recently provided for in state-based exchanges?

Answer: For 2014, CMS does not plan to provide links to stand-alone vision plans or other ancillary products in Federally-facilitated Marketplaces.

4. PPACA requires that out-of-pocket maximum cost-sharing limits – equal to those applied to high-deductible plans in any given year – apply to all group health plans beginning in plan year 2014. A recent FAQ released by the Departments of Labor, Health and Human Services, and Treasury (“Affordable Care Act Implementation (Part XII), February 20, 2013) proposes an interim policy for the 2014 plan year only, meant to ease the transition to PPACA standards for health plans that use multiple service providers to administer benefits (e.g. one third party administrator for major medical benefits, another for prescription drugs). The interim policy could result in enrollees paying twice the maximum out-of-pocket costs set by PPACA (where a plan has two different administrators) or potentially unlimited out-of-pocket costs (where a plan does not have an out-of-pocket maximum for prescription drugs). Such a policy would be unduly burdensome to individuals with rare diseases and would result in overwhelming costs for these highly vulnerable patients. Any advantages the interim policy creates by easing the transition for insurers are far outweighed by the significant risks it poses to patients and patient care. Can you please explain how this interim policy aligns with the policy goals envisioned by PPACA?

Answer: As noted in the Frequently Asked Questions (FAQs) that you reference, CMS recognizes that plans may currently utilize multiple service providers to help administer benefits (such as one third-party administrator for major medical coverage, a separate pharmacy benefit manager, and a separate managed behavioral health organization). In such situations, separate plan service providers often impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants’ expenses against any out-of-pocket maximums. These processes will need to be coordinated under section 1302(c)(1) of the Affordable Care Act, which may require new regular communications between service providers.

The February 20, 2013 FAQs state that only for the first plan year beginning on or after January 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums under section 2707(a) or 2707(b) of the Public Health Service Act, the Departments will consider the annual limitation on out-of-pocket maximums to be satisfied if both of the following conditions are satisfied:

- (a) The plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and
- (b) To the extent the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate

out-of-pocket maximum applies with respect to prescription drug coverage), such out-of-pocket maximum does not exceed the dollar amounts set forth in section 1302(c)(1).

Accordingly, any separate out of pocket maximum in 2014 would be limited to the amount set forth in section 1302(c)(1), although plans may choose to make it lower. However, existing regulations implementing Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prohibit a group health plan (or health insurance coverage offered in connection with a group health plan) from applying a cumulative financial requirement or treatment limitation, such as an out-of-pocket maximum, to mental health or substance use disorder benefits that accumulates separately from any such cumulative financial requirement or treatment limitation established for medical/surgical benefits. Accordingly, under MHPAEA, plans and issuers are prohibited from imposing an annual out-of-pocket maximum on all medical/surgical benefits and a separate annual out-of-pocket maximum on all mental health and substance use disorder benefits.

The Honorable Diana DeGette

- 1. There is a concern relative to the consistent application of rules on dental plans inside and outside of the Exchanges. In Colorado alone, over 15,000 children presently have dental coverage through plans in the small group market.**

Recent communications from the Center for Consumer Information and Insurance Oversight (CCIIO) regarding the offer and purchase of the pediatric dental essential health benefits have resulted in some confusion. Specifically, on the Colorado Exchange, the pediatric benefit must be offered but its purchase is not required. Outside the exchange, the purchase is mandated (even for childless adults) and responsibility for the reasonable assurance that an individual has purchased the pediatric dental benefit of purchase rests with the major medical carrier.

This lack of equitable treatment inside and outside exchanges may preclude children from receiving access to important oral services, as required by the Affordable Care Act. Can you clarify whether CCIIO will provide equitable treatment for the pediatric dental benefit which is so important to health of Colorado's children?

Answer: Several provisions of the Affordable Care Act affect the coverage of pediatric dental essential benefits. Section 2707(a) of the Public Health Service Act requires issuers in the individual and small group markets inside and outside the Marketplaces to offer EHBs as defined in section 1302 of the Affordable Care Act. EHB requirements apply to health insurance issuers, which must offer certain benefits; they are not requirements for individuals or families to obtain coverage for a particular benefit.

In the EHB Final Rule, CMS provided a clarification regarding situations in which issuers outside the Marketplaces would not be found to be non-compliant with the requirement to offer EHBs if the issuer is reasonably assured that the applicant has obtained the pediatric dental EHB through a Marketplace-certified stand-alone dental plan. With respect to issuers inside a Marketplace, however, section 1302(d)(4)(F) of the Affordable Care Act allows issuers to omit pediatric dental coverage if there is a stand-alone dental plan offering the pediatric dental essential benefit in that Marketplace. Thus, the different issuer requirements in the Affordable Care Act lead to different consumer experiences inside and outside of the Marketplaces.

The Honorable Ben Ray Luján

- 1. The Affordable Care Act called for the creation of Consumer Operated and Oriented Plans or CO-OPs, which will be offered on the health insurance exchanges as nonprofit insurance providers to compete with other carriers in the individual and group markets. This February, the co-op that will operate on my home state's exchange, New Mexico Health Connections received its certificate of authorization from the state insurance Superintendent, making it the first new health insurance company licensed by the state in 8 years. The progress of New Mexico Health Connections has been remarkable-they have announced that they will be ready to offer policies beginning on October 1 when the state exchange first opens for business-and they couldn't have done it without the help of CCIIO.**

The Co-op was initially underwritten with a \$6 million loan from the Centers for Medicare and Medicaid Services that will be repaid within 5 years and has taken advantage of another \$64 million line of credit with CMS to be repaid in 15 years. In our current fiscal climate, these co-ops present a terrific investment opportunity for the federal government. These startup funds can be utilized to expand the reach of co-ops to bring more Americans into an affordable plan that promises to bring sorely needed competition to the individual health insurance market. Best of all, the co-ops have plans in place to become self-sufficient and fully re-pay the federal government for its contribution.

Mr. Cohen, could you please further discuss the federal government's role in funding these co-ops and how you foresee the role of the government in sustaining them into the future? I am particularly interested in opportunities for CCIIO to further expand the reach of the co-ops as they go online and seek to provide health coverage for additional customers.

Answer: We are pleased to have established the CO-OP Program, authorized by section 1322 of the Affordable Care Act, to foster the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets.

To date, 24 private, nonprofit entities have been awarded loans to establish CO-OPs across 24 states. Because such funds are considered to be obligated when the awards are made upon execution of a loan agreement, loan or grant awards issued to CO-OPs prior to enactment of the American Taxpayer Relief Act are not subject to or affected by the rescission.

CMS will continue to provide assistance and oversight to these CO-OPs as they work to achieve program milestones, receive licensure from their respective state Departments of Insurance, qualify as a Qualified Health Plan, and prepare to participate in new Health Insurance Marketplaces.

While CMS no longer has the authority to make loan awards to new borrowers, it can provide additional funding to existing borrowers, including funds for expansions to new states. CMS is currently accepting and reviewing these applications submitted by existing borrowers.

The assessment process for additional funding is rigorous. The available program funds will be prioritized first to ensure the viability of the existing business plans, and secondly to fund modifications to business plans for the purpose of expanding to new states. Expansion requests will be reviewed by both a contractor and CMS against the same scoring criteria as were the original loan applications. Preference will be given to expansions that align with the program goal of increasing consumer choice in states that may otherwise face limited issuer competition in their Health Insurance Marketplace.

CMS will closely monitor CO-OPs to ensure they are meeting program goals and will be able to repay loans. To ensure strong financial management, CO-OPs are required to submit quarterly financial statements, including cash flow and enrollment data, receive site visits, and undergo annual external audits. This monitoring is initially conducted by CMS and will continue concurrently with the financial and operational oversight by state insurance regulators once the CO-OP is approved for state licensure. We look forward to our continued collaboration with these CO-OPs to provide more options for Americans as they access health insurance coverage in the new Marketplaces.

- 2. I represent a very rural state in which patients sometimes have to drive several hours just to speak with their health care providers. There are no requirements in the Exchange final rules that specify the minimum distance for access to providers or minimum time frames in which to access the providers. However, guaranteeing network adequacy is a particularly important issue for individuals with ESRD, given that such individuals' lives depend on their ability to access dialysis treatment at least three times each week. Peer-reviewed literature (e.g. in the American Journal of Kidney Disease) has confirmed that increased drive time is correlated with diminished health outcomes for ESRD patients. These same studies have shown that a significant majority (3 out of 4) of ESRD patients currently have drive times that are within 30 minutes.**

I understand, due to the geographic variability of many states, a single standard distance or time frame for all providers may prove to be difficult. On the other hand, network adequacy is a key indicator with respect to proper plan design, particularly in the case of individuals with significant health needs. Unfortunately, as the NAIC noted in a December 19, 2012 letter to CMS, "State insurance regulators continue to have questions regarding how the prohibition on discriminatory benefit design is to be defined and enforced" and "need more clarity on what is a 'discriminatory benefit design.'" Would HHS consider issuing clarifying regulatory language to provide, in the case of individuals with significant health needs, that plans may not contain network adequacy criteria that are more restrictive than those established under the state benchmark plan?

Answer: The Exchange Establishment Final Rule (77 FR 18310), 45 C.F.R. § 156.230 requires QHP issuers to develop provider networks that (1) include essential community provider described in 45 C.F.R. 156.235, and (2) are sufficient in number and types of providers,

including providers that specialize in mental health and substance abuse service, to assure that all services will be accessible without unreasonable delay.

Health plan network adequacy is an area reviewed by many state departments of insurance today; consistent with CMS' overarching commitment not to duplicate state work in carrying out its responsibilities with respect to a Federally-facilitated Marketplace, CMS will implement a tiered approach to network adequacy reviews. In states with sufficient authority and means to evaluate health plan network adequacy consistent with the Federal regulatory standard, CMS will use a state's review as part of its evaluation. In states without such authority, CMS will rely on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting agency. Unaccredited issuers will be required to submit an access plan as part of the QHP Application. The access plan must demonstrate that an issuer has standards and procedures in place to maintain an adequate network consistent with § 156.235(a).

CMS intends to monitor consumer access to providers, including specialists, during the coverage year, and will work closely with states in which an FFM is operating.

In addition, as part of the certification process in FFMs CMS will work to ensure that potential QHPs do not employ discriminatory benefit designs. Specifically, CMS will use an outlier test to identify potential QHPs with relatively high cost sharing for benefits like specialist visits and prescription drugs. More information about CMS's approach for reviewing both network adequacy and benefit designs is included in the 2014 Letter to Issuers, available at:

http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

3. As a strong supporter of one of the ACA, I am eager to see that the law is implemented properly. As the exchanges begin enrolling people this fall, I want to be sure that my constituents have access to all of the important care and services they need. I understand that the recent Essential Health Benefits rule may inadvertently restrict access to care for patients suffering from rare diseases. Exactly how will you ensure that my constituents suffering from these diseases are not inadvertently discriminated against by qualified health plans in the exchanges?

Answer: The EHB Final Rule at 45 CFR 156.125 outlines non-discrimination standards for issuers offering EHBs. The regulation provides that an issuer's benefit design, or the implementation of its benefit design, may not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. In guidance issued on April 5, 2013, entitled, *Letter to Issuers on Federally-facilitated and State Partnership Exchanges*, CMS further detailed the steps it will take to review plans for discriminatory benefit design as part of the Qualified Health Plan (QHP) certification process in Federally-facilitated and State partnership Marketplaces.

4. One of the goals of the ACA was to ensure that none of our constituents fell through the cracks of our complex healthcare system. Congress enacted a number of protections into the bill to ensure patients have access to the care they need. As the exchanges open for business later this year, I want to be sure that we continue to keep those promises to

patients, particularly those who suffer from rare diseases. Many of these patients require specialized care. What are you doing to ensure that qualified health plans operating in the exchanges will have robust networks of providers so that my constituents are not left with few or no options for treatment for their rare diseases?

Answer: CMS finalized network adequacy standards in the Exchange Establishment Final Rule (77 FR 18310), in sections 45 CFR 155.1050 and 45 CFR 156.230. The Final Rule states that a QHP issuer must maintain a provider network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay. In addition, QHP issuers must meet the requirements to include essential community providers in accordance with 45 CFR 156.235 and meet the network adequacy provisions of section 2702(c) of the Public Health Service Act. The standards articulated are a floor. Nothing prohibits states from applying more stringent standards or protections across their markets. New Mexico has elected, and has been conditionally approved, to run a State-based Marketplace. As a result, New Mexico will review plans for compliance with network adequacy standards.

5. I understand that the Essential Health Benefits Rule that was recently issued by HHS allows qualified health plans to employ “reasonable medical management techniques,” but that issues could not use such techniques “in a manner that discriminates on the basis of membership in a particular group...” One such technique that is often used is to place certain medications into ‘specialty tiers’ with higher cost-sharing for patients. I am concerned that this may cause undue harm to rare disease patients. How will you ensure that this will not happen to the most vulnerable rare disease patients?

Answer: CMS’ implementing regulations neither require nor prohibit prescription drugs being covered on any particular tier, if a plan chooses to use a tier system in its formulary. Instead, the rule requires the plan to offer at least the greater of one drug in every USP category and class or the number of drugs in each USP category and class offered by the EHB-benchmark. However, the EHB Final Rule at 45 CFR 156.125 outlines non-discrimination standards for issuers offering EHBs, which apply to all EHBs including prescription drug benefits. The regulation provides that an issuer’s benefit design, or the implementation of its benefit design, may not discriminate based on an individual’s age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Lastly, the Final Rule requires that plans have an exceptions procedure for enrollees to request and gain access to a clinically appropriate drug not covered by the health plan.

The Honorable G.K. Butterfield

- 1. As you may know, the Republican-controlled North Carolina General Assembly passed and Governor Pay McCrory signed a bill called the “No NC Exchange/No Medicaid Expansion.” The decision by the legislature and Governor defies logic. The Federal government will pay 100 percent of the cost of expanding Medicaid for three years and then pay 90 percent after that. This shortsighted decision continues to exclude single, childless adults who make less than 100 percent of poverty-some 500,000 people. Some estimate it may be as high as 650,000. What will the individuals who fall into that category be forced to do when they become sick? And doesn’t that decision by the Governor and General Assembly essentially force those individuals who do not qualify for Medicaid to go to an emergency room where they will likely not be able to afford the bill once they are treated?**

Answer: CMS agrees that expanding Medicaid has financial and social benefits for states, with the Federal Government covering 100 percent of the cost of covering Medicaid for newly eligible low-income adults under age 65 for the first three years and no less than 90 percent in following years. This expanded coverage would dramatically reduce uncompensated care in emergency rooms and other care settings, lowering the financial burden on hospitals, providers, employers, and patients.

CMS continues to work with states on Medicaid-expansion implementation. There is no deadline by which a state must notify the Federal Government of its intent to expand its Medicaid program, and states may choose to expand Medicaid at any time. However, while states have flexibility regarding how they implement the Medicaid expansion, Federal match rates for medical assistance for newly eligible individuals are statutorily tied to specific calendar years: states will receive 100 percent support for the newly eligible adults in 2014, 2015, and 2016; 95 percent in 2017, 94 percent in 2018, 93 percent in 2019; and 90 percent in 2020, remaining at that level thereafter.

- 2. Say a 35 year old single man from Rocky Mount, North Carolina who doesn’t smoke and is just above the poverty line is searching for health insurance under the Marketplaces in 2014. If our Governor had been wise enough to expand Medicaid, he would have had that option. But on the exchange, my constituents will get a tax credit to keep his premiums at around 2% of their income. Is that correct? Will this credit enable individuals to access more comprehensive coverage with lower premiums than exist currently?**

Answer: Yes. In general, under the Affordable Care Act, qualified individuals with incomes between 100 and 400 percent of FPL, who are not eligible for certain health insurance coverage through their employer, Medicaid, Medicare, or certain other types of coverage, and who purchase insurance coverage through the Marketplaces, are eligible for tax credits to reduce the cost of coverage. The amount of the tax credit is based on a benchmark premium: the premium for the second-lowest-cost silver plan (a plan that provides EHBs and has an actuarial value of 70 percent) available in the Marketplace where the individual is eligible to purchase coverage. The amount of the tax credit also varies with the individual’s income, such that the premium for

the benchmark plan for an individual earning 100-133 percent FPL would be capped at 2 percent of the individual's household income. CMS expects that these tax credits, coupled with the Affordable Care Act's insurance market reforms, will enable access to affordable, comprehensive insurance without discrimination based on gender or pre-existing conditions.

3. In all my conversations with state and local officials in my Congressional District and across my state of North Carolina, I emphasize how important it is that everyone who doesn't have insurance knows they will be required to enter the insurance marketplace. HHS has developed an "exchange navigator program" designed to help guide people through the process. Can you please explain how the navigators will measure progress and if you feel that the resources made available for the program are sufficient?

Answer: On April 9, 2013, CMS published a Funding Opportunity Announcement (FOA) making up to \$54 million available in cooperative agreements to fund Navigators in Federally-facilitated and State Partnership Marketplaces, including North Carolina, with a minimum amount of \$600,000 available per Federally-facilitated or State Partnership Marketplace service area. This funding will be sufficient to provide Navigator services in the states that will have Federally-facilitated or State Partnership Marketplaces. Navigator cooperative agreement applications are due on June 7, 2013. The President's Fiscal Year (FY) 2014 Budget includes \$574 million, or a total program level over \$800 million when accounting for user fees, for Marketplace outreach activities, primarily the call center, Navigator grants, and other enrollment assistance, with a smaller portion allocated to the website, print communications and other awareness activities.

As a condition of their cooperative agreement awards, Navigators in the Federally-facilitated and State Partnership Marketplaces must agree to cooperate with any Federal evaluation of the program and must provide required quarterly and final progress reports. The reports will outline how cooperative agreement funds were used, describe program progress, describe any barriers encountered including how potential conflicts of interest were mitigated and process for handling non-compliant staff or volunteers, describe how the program ensured access to culturally and linguistically appropriate services, and detail measurable outcomes including how many staff and volunteers completed training and became certified Navigators and how many consumers were served.

4. I understand the navigators will provide help to customers through the eligibility and enrollment process. For a low income, African American from Roanoke Rapids, North Carolina with hereditary medical issues, will the navigators be able to provide suggestions about the best plans to fit their health care and financial needs?

Answer: Navigators will help consumers through the eligibility and enrollment process, but will not make eligibility determinations and will not select qualified health plans (QHPs) for consumers or enroll applicants into QHPs. That said, Navigators may play an important role in facilitating a consumer's enrollment in a QHP by providing fair, impartial, and accurate information that assists consumers with submitting the eligibility application, clarifying the distinctions among QHPs, and helping qualified individuals make informed decisions during the health plan selection process.

In addition, Navigators will maintain expertise in eligibility, enrollment, and program specifications and will conduct public education activities to raise awareness about the Marketplace. Navigators will provide information and services in a fair, accurate, and impartial manner, including information that acknowledges other health programs such as Medicaid and CHIP. Navigators will also provide referrals for enrollees with questions, complaints, or grievances about their health plan, coverage, or a determination under such health plan or coverage to appropriate State agencies, such as any applicable office of health insurance consumer assistance or health insurance ombudsman. Navigators must provide information in a manner that is culturally and linguistically appropriate to the needs of the population served by the Marketplace, including individuals with limited English proficiency, and must ensure accessibility and usability of Navigator tools and functions for individuals with disabilities.

5. If I live in Durham, North Carolina and have been diagnosed with a pre-existing condition but missed the February cutoff for enrollment in the Pre-existing Condition Insurance Program (PCIP), what are my insurance options until the implementation of the Marketplace in 2014?

Answer: Starting in 2014, health insurance issuers will no longer be able to discriminate against Americans with pre-existing conditions. All Americans – regardless of their health status or pre-existing conditions – will finally have access to quality, affordable coverage. On October 1, 2013, Americans with pre-existing conditions will be able to apply for affordable health insurance coverage through the new Health Insurance Marketplace.

Marketplaces will be up and running and ready to serve all Americans, including those with pre-existing conditions, on October 1st of this year. Until then, a variety of options may be available to those with pre-existing conditions who are not enrolled in PCIP. For example, they may be eligible for Medicaid or a state high risk pool. Individuals with pre-existing conditions may visit <http://finder.healthcare.gov> to explore their health care options.

6. As you know, states like North Carolina originally intended to establish a state-federal partnership health insurance exchange but at the last minute decided to rely on the federal government to operate the exchange. Is implementation for Federal Marketplaces in states like North Carolina still on track?

Answer: Implementation of the Federally Facilitated Marketplaces is on track, and on October 1, 2013, consumers will be able to apply for coverage and premium tax credits, receive an accurate eligibility determination, compare QHPs and choose the plan that best fits their needs. CMS has released the final model single streamlined application after extensive testing for consumer usability. The infrastructure for the data hub, which will facilitate data exchange between consumers and relevant government agencies, has been completed and testing has been successful. CMS met its April 1st deadline for allowing issuers to submit QHP applications, and states have successfully used the Hub in testing. We expect each of these systems to be fully operational and interoperable by open enrollment on October 1.

7. It is my understanding that waiver process for employers and ensures was simple, fair, and transparent. Do waivers continue to be granted at a high rate and in a timely manner?

Answer: The Affordable Care Act was clear that restricted annual limits on EHBs would be permitted until 2014 to prevent changes that would increase premiums or reduce access. The waiver policy adheres to the law without creating a blanket rule that exempts many more health insurance issuers and group health plans from the new protections against restricted annual limits. Most health insurance issuers and group health plans determined that they could comply with the new policy that restricted annual limits to no less than the following: \$750,000 for plan years between September 23, 2010 and September 22, 2011; \$1.25 million for plan years between September 23, 2011 and September 22, 2012; and \$2 million for plan years between September 23, 2012 and December 31, 2013. However, health insurance issuers and group health plans were able to apply for and receive a waiver if they could show that the prohibition against restricted annual limits would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies. Plans that received waivers have been required to let their enrollees know that they received waivers from the new protections in the law. This balanced approach reflects our goal of not disrupting coverage while expanding consumer protections as we move toward full implementation – and a full prohibition of annual limits – in 2014. The deadline for plans to apply for these waivers was September 22, 2011, and we stopped issuing waivers on January 6, 2012. A list of the waivers is available at: http://www.cms.gov/CCIIO/Resources/Files/approved_applications_for_waiver.html. All annual limit waivers expire for the plan or policy year that begins on or after January 1, 2014.

8. Some states (e.g. California) have enacted legislation to prohibit treatment limits from exceeding the corresponding limits imposed by the state benchmark plan and would generally prohibit a plan from making substitutions of the benefits required to be covered. Do you believe the EHB Final Rule will comport with such legislation? Would HHS consider clarifying regulatory language to provide, in the case of individuals with significant health needs, that plans may not contain treatment limits which exceed the corresponding limits imposed by the benchmark plans or make substitutions of the benefits required to be covered under the benchmark plan?

Answer: State requirements that are more stringent than the Federal requirements would not be preempted by the EHB Final Rule unless such requirements prevent the application of Federal law. Accordingly, states have significant latitude to impose requirements with respect to health insurance coverage that are more consumer-protective than the Federal law, including with respect to benefit substitution under EHBs.

9. Can you please describe how much, and what type of information will be available to consumers when they are ultimately able to make coverage choices in the health insurance marketplace? Will it look like Medicare Part D? Or perhaps Medicare Advantage?

Answer: To access the Marketplace, consumers can visit HealthCare.gov, which will guide them to the appropriate application – state applications for State-based Marketplaces, or the single, streamlined HHS-developed application in states with a Federally-facilitated Marketplace or State Partnership Marketplace.

After an applicant receives an eligibility determination, the applicant will then either proceed to the Plan Compare section of the Marketplace website, or to the State-specific process for Medicaid or CHIP enrollment, depending on the final eligibility determination.

In the Plan Compare section of the Federally-facilitated Marketplace website, eligible applicants will be able to learn more about available QHP options and compare the plans based on a number of factors including price, benefits, and quality. Applicants will be able to compare plans across metal levels and also within a metal level. For example, an applicant can compare three different “silver” level plans or they may want to compare a “silver” plan to a “gold” and a “bronze” to learn what each plan offers for them and at what cost. Applicants will be able to review information for each plan such as: monthly premium (after any applicable premium tax credit); deductible; out of pocket maximum; co-pay amounts; and dental options available. Applicants will also be able to easily link to a summary of benefits and coverage, provider directories, and other plan details. This consumer-driven tool will allow applicants to easily compare the QHPs available to them, helping them make the best decision for their and their family’s needs.

The Honorable Paul Tonko

- 1. The implementation of the Affordable Care Act will extend federal parity protections from Mental Health Parity and Addiction Equity Act to more than 62 million Americans. However, given the lack of clarity stemming from the delay of the Obama Administration in issuing final parity regulations, it remains to be seen whether the American people will enjoy the full protections of mental health parity consistent with the spirit of MHPAEA as the ACA goes into full effect in 2014. Last week, Secretary Sebelius testified that a final Mental Health Parity regulation would be finished by the end of the year. Can you provide us with any more details on when to expect a final parity rule?**

Answer: As you note, the Administration has committed to releasing a MHPAEA Final Rule this year. I expect that the regulation will specify an effective date. Until the Final Rule is issued, the Interim Final Rule implementing MHPAEA, which was published in the Federal Register on February 2, 2010, remains in effect.

- 2. While it is promising new that final parity regulations will be released this year, I fear that it will be too late for insurance plans to implement for their 2014 plan year. Can you specifically tell us whether the administration expects final parity rules to be in force for their 2014 plan year, consistent with the roll out of the ACA?**

Answer: See response to question 1.

- 3. Along with promulgating a final rule, there are significant concerns that the administration is not doing enough to enforce the interim final regulations that are already in place. Just this week, an employee from CCHIO was quoted in an article in CQ Weekly, speaking in front of representatives of the health insurance industry that mental health parity was, “an area where we plan on setting the dials pretty low.” I find this attitude to be very troubling. Can you please explain what was meant by this statement and speak generally to the Administration’s posture towards MHPAEA enforcement?**

Answer: The Department of Labor, the Department of Health and Human Services (HHS), and the Department of the Treasury (the Departments) are committed to full implementation and enforcement of MHPAEA, including the provisions of the interim Final Rules that were published on February 2, 2010. The President and his Administration are fully committed to promulgating a MHPAEA Final Rule in 2013. We share your interest in ensuring that group health plans, health insurance issuers, health care providers, and consumers are provided the guidance necessary to realize the full benefits of the law.

The Department of Labor and the Department of the Treasury generally enforce the requirements for private, employment-based group health plans, but do not have enforcement authority under MHPAEA over health insurance issuers. Under the Public Health Service Act section 2723(a), states have primary enforcement authority over health insurance issuers with respect to the provisions of title XXVII of the Public Health Service Act, including MHPAEA. HHS (through

CMS) has enforcement authority over the issuers in a State if the State notifies CMS that it has not enacted legislation to enforce or is not otherwise enforcing, or if CMS determines that the State is not substantially enforcing, a provision (or provisions) of title XXVII of the Public Health Service Act. CMS also has direct enforcement authority with respect to non-Federal-Government plans. The Department of Labor and the IRS have enforcement authority over private group health plans.

The Departments recognize that many States have existing insurance laws requiring parity for or requiring coverage of mental health or substance use disorder benefits and that it can at times be difficult to understand how the Federal MHPAEA requirements interact with such provisions of State law. The Departments regularly work with state regulators through the National Association of Insurance Commissioners and on an individual basis to ensure that states understand MHPAEA and its implementing regulations and are aware of their enforcement responsibilities. In addition, the Departments communicate regularly with state regulators, health plans, issuers, providers, consumer organizations, and congressional staff to discuss MHPAEA implementation issues.

Beginning in 2014, many Americans will experience expanded access to mental health and substance use disorder benefits. Section 2707(a) of the Public Health Service Act and section 1302 of the Affordable Care Act provide that health insurance coverage in the individual and small group markets must include coverage for 10 categories of EHBs. One of those categories is mental health and substance use disorder services, including behavioral health treatment. HHS issued a Final Rule related to EHBs on February 25, 2013. Under this Final Rule, starting in 2014, all individual policies and small group plans sold both inside and outside a Health Insurance Marketplace must provide mental health and substance use disorder benefits in compliance with the requirements of the MHPAEA interim Final Rule. In addition, large group health plans will continue to be subject to MHPAEA.

In preparation for 2014, many states have reached out to HHS with questions concerning how to structure the benefits within EHB-benchmark plans to comply with MHPAEA. For benefit years 2014 and 2015, states selected “base-benchmark plans” from four types of health plans, including the largest plan by enrollment in any of the three largest small group insurance products in a state’s small group market. Because EHB-benchmark plan benefits are based on 2012 plan designs, and include state-required benefits that were enacted before December 31, 2011, some of the benchmark plan summaries may not reflect requirements effective for plan years starting on or after January 1, 2014. Therefore, HHS has been informing stakeholders that, when designing plans that are substantially equal to the EHB-benchmark plan, beginning in 2014, issuers may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations, including compliance with the requirements of the MHPAEA interim Final Rule. State regulators have appreciated HHS’s guidance on MHPAEA at this crucial stage, especially given that all individual policies and small group plans sold both inside and outside a state marketplace must comply with states’ EHB-benchmark plans in 2014.

4. Can you describe in step-by-step detail the current investigation and enforcement procedures that your office goes through when it receives a complaint about parity violations?

Answer: Plans subject to MHPAEA may be regulated by different entities, depending on the type of plan. States have primary regulatory authority over health insurance issuers, unless a state is not enforcing a Federal law, in which case CMS is required to enforce the law. This enforcement structure has been in place since the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CMS also enforces MHPAEA requirements for non-Federal Governmental plans. The Department of Labor and the Department of the Treasury generally enforce the requirements for private, employment-based group health plans, but do not have enforcement authority under MHPAEA over health insurance issuers. If CMS receives a complaint about a MHPAEA violation, we investigate it and take enforcement action as appropriate to ensure that the law protects consumers as intended. CMS and other Federal agencies work closely with plans, state departments of insurance, and issuers to ensure any MHPAEA violations are corrected.

The two primary methods in which consumers and providers contact CMS with inquiries about MHPAEA are a toll-free phone number (1-888-393-2789) and an email address (phig@cms.hhs.gov). The caseworkers within CCIIO's Consumer Support Group, who have received MHPAEA training, gather information about the consumer's or provider's issue and answer basic questions about the law.

In addition to following up on inquiries and complaints, the Departments of Health and Human Services, Labor and the Treasury (the Departments) have released fact sheets and interpretive guidance to increase the public's understanding of this complex law. For example, the Departments issued Frequently Asked Questions (FAQs) regarding MHPAEA on December 22, 2010, and November 17, 2011, to address several common questions from stakeholders. These FAQs reflect the Departments' interpretation of the requirements in the interim Final Rule and applicable Federal law. Also, HHS has posted a fact sheet on MHPAEA. Both resources are available at: <http://www.cms.gov/ccio/index.html>.

5. When these investigations of parity violations are concluded, are the results of these investigations made public? If not, why?

Answer: The results of the Department's investigations of parity violations are not made public at this time. The Department recognizes stakeholders' desire for more transparency and will coordinate to formulate methods to disseminate information on parity compliance.

6. Will you commit to releasing more of the information regarding the administration's parity investigations so that insurers and patients will have greater clarity as to when parity violations have been committed?

Answer: The Department appreciates the need for insurers and patients to have greater clarity as to when parity violations have been committed, specifically regarding the Administration's parity investigations. We will coordinate to develop a process to disseminate information on

parity compliance so that stakeholders will have additional information on the enforcement efforts of the Department.

The Honorable Gene Green

1. **Congress' intent with the ECP provision was to ensure sufficient access to safety net providers, including Community Health Centers among others. I want to ensure that as this rolls out, your agency is continuing to monitor the extent to which these plans do contract with ECPs and that your agency updates its guidance accordingly-especially if QHPs are offering untenable or limited contracts to safety net providers who wish to contract with them.**

In fact, as ACA implementation rolls out it will be vitally important to link access to coverage and ensure people can see access the important primary and preventative care services they need (and avoid unreasonable delays to care). And so, Congress' intent was that any willing safety net provider should be able to contract with any Qualified Health Plan-especially those providers who are open to all, such as Community Health Centers, and who are located in areas where there are already sever barriers to accessing primary and preventative care. Looking forward to how this will roll out-both in terms of the contracting requirements for this current year and also in terms of continued guidance for the future, can you tell me how your agency will be monitoring this issue, what would be considered "robust participation"-since the 10% contracting requirements could mean just one single provider, which certainly would not be robust-and what your plans are for updating this guidance down the road?

Answer: For the 2014 coverage year, CMS will implement a threshold-based approach to evaluating the inclusion of essential community providers, or ECPs, in QHP provider networks. QHP provider networks may satisfy the regulatory requirement at 45 CFR 156.235 in one of three ways.

First, an issuer's networks may satisfy the safe harbor standard. To qualify for this standard, an issuer's QHP application must demonstrate that at least 20 percent of available ECPs in the plan's service area participate in the issuer's provider network(s). In addition to achieving 20 percent participation in available ECPs, the issuer must offer contracts prior to the coverage year to at least one ECP in each ECP category in each county in the plan's service area, and all available Indian providers.

Second, an issuer's networks may qualify for the minimum expectation standard. To satisfy the minimum expectation standard, an issuer's must demonstrate that at least 10 percent of available ECPs in the plan's service area participate in the issuer's provider networks. The issuer must also submit as part of the QHP application a narrative response describing how the issuer's provider networks, as currently designed and after taking into account new 2014 enrollment, provides an adequate level of service for low-income and medically underserved enrollees. This narrative justification should address the needs of specific underserved populations, including individuals with HIV/AIDS, American Indians/Alaska Natives, and low-income and underserved individuals seeking women's health and reproductive health services.

For an issuer that does not meet either the safe harbor standard or the minimum expectation, CMS will expect the application to include a narrative justification describing how the issuer's provider

network(s) will provide access for low-income and medically underserved enrollees and how the issuer plans to increase ECP participation in the issuer's provider network(s) in future years.

To assist issuers in identifying available ECPs, CMS published a non-exhaustive list of available ECPs based on data maintained by CMS and other Federal agencies, including provider names, contact information, and ECP type. CMS also published a list of providers who offer dental services to assist issuers of stand-alone dental plans.

CMS intends to monitor ECP participation during the coverage year to ensure that medically underserved and other consumers have adequate access to ECPs, and will continue to solicit feedback from the ECP community. As indicated in the 2014 Letter to Issuers, CMS may modify network adequacy and ECP standards in future years based on program experience.